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EDITORIAL

Lessons from New Zealand

In a booklet entitled "Social Security Services in New Zealand,"* Dr. Maples (doctor of laws, not of medicine) gives an interesting survey, the result of a two months' visit by an intelligent observer, in which he was given every facility for seeing what is happening in that Dominion. He rightly points out the very important differences between New Zealand and this country; the former being the larger, but with a population of 1,800,000 (17·5 persons per square mile compared with our 543) in parts very mountainous and sparsely populated, with the populous centres widely separated, and with no poor as we understand the term—these conditions making it impossible to provide, except in the larger towns, services such as we have in England. But New Zealand has pioneered social security measures (particularly in the medical field) which may yet be used as pointers for developments of services here, and Dr. Maples' observations therefore deserve careful notice.

It will be recalled that, after the B.M.A. in New Zealand successfully resisted introduction of capitation fees in 1941, a system of fees for services, reclaimable from the Government, was substituted; Dr. Maples considers that the method of payment for each visit should in no circumstances be adopted in England, that the income earned by the New Zealand general practitioner is out of all proportion to that earned by the specialist; that the scheme gives no encouragement to the individual doctor to gain further experience or to increase his skill; and among other points that the patient-pressure on the doctor will increase materially (this already having produced a national bill in 1947–48 of over £7,500,000 for pharmaceutical benefits alone). The total sum in that year spent on medical and allied services (including maternity benefits) was £7,000,000 which, although it is causing disquiet in New Zealand, seems rather less per head than the current cost of our own National Health Service. The New Zealand hospitals, however, are also financed by the local rates, so a true comparison is not possible.

One feature from New Zealand is strongly recommended by Dr. Maples for adoption in Great Britain. That is the system of dental nurses, introduced in 1919. These nurses receive two years' training and thereafter carry out all dental work in the primary schools, including extractions, fillings, general dental hygiene and the giving of local anaesthetics. At adolescence the child passes to the care of the dentist under Social Security. Our own Dental Officers' Group has debated the New Zealand system, which seems to have achieved the same happy relations between patient and dental nurse as between patient and dentist in our own school service. But we cannot believe that the Dominion's lead needs to be followed here, unless procrastination over remuneration and service conditions drives all our school dentists over to general practice.

* Copies obtainable from Dr. E. W. Maples, O.B.E., LL.D., D.L., J.P., 59, Bodenham Road, Hereford, provided that a stamped addressed envelope, 9 by 6 inches, is enclosed.

The Physique of Great Britain

The Medical Research Council Memorandum No. 20 (1949), "The Physique of Young Adult Males,"* by W. J. Martin, D.SC., PH.D., from the Statistical Research Unit of the M.R.C., is an account of a statistical analysis of the examination of 91,513 men called up for examination under the Military Training Act, 1939, before the outbreak of war. The analysis compares natives from county boroughs, urban districts and rural districts. In weight, height and chest circumference, "the countryman was, on the average, larger than the town dweller"; "the average standard of fitness of the countryman was also higher than that for the townsman"; "rural districts had 10·6% more men with perfect vision than the county boroughs." A regional analysis showed on the whole that "the average physique is slightly greater in the south than in the north, while the eastern and most of the midland counties occupy an intermediate position in this regard." When the analysis is carried still further into sub-divisions of regions into administrative areas, Dr. Martin says "in all regions the rural dweller is heavier than his counterpart" and, "in general, it may therefore be concluded that the higher standard of physique and lower incidence of defects presented by the countryman in comparison with the town dweller for the country as a whole is a feature of all parts of the country." The native born Londoner was, however, "superior in physique to the average throughout Great Britain." The men from the counties of Cumberland, Durham, Northumberland and Westmorland, which had suffered from poor economic conditions during the years of their rapid growth, although amongst the shortest and lightest in the county, had a high standard of fitness. "In physical measurements the Highlanders were, on the average, superior, their mean weight ranging from 4 to 9·2 lb., and their mean height from 0·5 to 1 inch, above those of the recruits from the other regions, but they had no corresponding advantage in the other indices of physical fitness." "Compared with the average value for the whole of Great Britain, Welshmen were 1·7 lb. lighter,

* H.M.S.O. Pp. 66. Price 1s. 3d. net.

0·4 inch shorter, and equal in chest circumference." The Welshman's fitness differed little from the average.

An attempt is made to compare these findings with those of earlier investigations, although, as Dr. Martin says, "it is impossible to make a fully satisfactory comparison . . . because of the methods, and periods of collecting the data." The army recruits of 1939 "were on the average larger men than the recruits of 1918" (being about 2 inches taller and 18 lb. heavier), but some of the difference may be attributable to an earlier maturity which seems to take place to-day.

In comparison with the earliest known records of Beddoe (1870), the modern Englishman is 9½ lb. lighter and 1 inch taller, while the Scotsman is 10 lb. lighter and ½ inch less in height. Precisely what statistical reliability can be attributed to Beddoe's data (composed of private records, official recruiting figures, records of criminals and lunatics) is not made very clear. In comparison with Cathcart's observations of 1935, the men of 1939 were 7 lb. heavier and ½ inch taller. Stature in 1939 was identical with that recorded by the British Association Anthropometric Report, 1883, but the 1939 weight was 22½ less than that in 1883.

For what these figures are worth, they seem to suggest a decline in both height and weight (about 30 lb. in weight and 2 inches in height) from the end of the third quarter of last century until some time in this century, with a recovery since 1918 (or earlier) in both measurements (about 20 lb. in weight and 1 inch in height). The whole Report is worthy of study.

A New Height and Weight Chart

Whilst valuable investigations are being carried out regarding the correlation of various body measurements with physical fitness, a realistic attitude has to be taken that at present it is generally possible to ascertain the weight and height only of school children. It is of interest to consider a chart, therefore, which has been devised to lend itself "to wide distribution" and to sound yet ready use by the school nurse, the physical education instructor or the one room rural school teacher. The resulting Physical Growth Record* is in the form of a four-page booklet, each designed for recording the growth in height and weight of a single child. Pages 1 and 4 of the booklet describe how to measure height and weight, how to register the measurements made, and how to interpret the status and progress thus obtained. Pages 2 and 3 provide charts covering the age period 4 to 18 years for graphically depicting the growth of the individual in relation to the growth of norms. The height graph is shown above the weight graph and there are separate forms for boys and girls. Apart from recording "body sizes" at each of the ages that measurements have been taken, it is suggested that the charts can also be used for interpreting the child's physical progress. Both in the height and weight graphs, the "norms" have been divided into zones according to percentile value of the measurements which were obtained in a sample of the elementary and high school population.

Accordingly, in the height portion of the chart, the graph shows six series of height percentiles, and are precisely described as follows: The "short zone" is delimited by the 1st and 10th percentiles, the "moderately short zone" by the 10th and 30th percentiles, the "average zone" by the 30th and 70th percentiles, the "moderately tall zone" by the 70th and 90th percentiles, and the "tall zone" by the 90th and 99th percentiles. Correspondingly, the materials presented graphically in the weight portion of the chart were drawn to the six series of weight percentiles, the "light zone" being bounded by the 1st and 10th percentiles, the "average zone" by the 30th and 70th percentiles, and the "heavy zones" by the 90th and 99th percentiles.

It is interesting to note that the author of this article was the joint author of the proposals "that basic measurements in addition to those of height and weight should be taken wherever possible." (See PUBLIC HEALTH, April, 1947.) In this connection the investigations sponsored by the Ministry of Health are continuing in the endeavour to ascertain the value of various body measurements in addition to height and weight in estimating physical fitness.

The height-weight relationship has been the subject of many investigations, and among the most recent may be mentioned those of Wetzel and Bransby. Although the latter found standard height × weight growth curves preferable to standard weight × age curves for assessing the adequacy of growth, there would seem to be a use for the physical growth record described above. The examiner can at once see in what portion of the distribution a child fell with respect to each measurement taken, and can also compare the positions held for the different measurements at the time and note whether the same positions are maintained from one examination to another. The norms for the records were obtained from white children of North-West European ancestry living under better than average conditions in Iowa City.

A plea is once more made for a percentile ranking of norms of heights and weights for this country, possibly of the distribution obtained for the tables of average measurement of London elementary school children in 1938 published by the London County Council (1939). These measurements are mentioned advisedly as they are now being regarded as the standard. (Report of the Chief Medical Officer of the Ministry of Education for the years 1939–1945.)

* A Physical Growth Record for Use in Elementary and High Schools. *Am. J. Publ. Health* (1948), **39**, 878–885.

Comparative Risks of the Common Infections in Infancy

Dr. W. P. D. Logan, of the General Register Office, writing in the *Monthly Bulletin* of the Ministry of Health and P.H.L.S. for July, 1949, discusses the mortality in infants in the first year of life from seven common infections during the period 1911–47. He reminds us that deaths among infants make a substantial contribution towards the total mortality from these diseases; for instance, in 1941–47 about half the deaths at all ages from whooping cough and chickenpox, and a third of the deaths from measles and rubella, were in infants. His table showing how the proportions have varied for the ten-year periods since 1911 records how the proportion of infant deaths from whooping cough, measles and rubella rose sharply between 1931–40 and 1941–47, and less steeply for the other infections (mumps, scarlet fever, diphtheria and chickenpox).

Other tables show mean annual death-rates under one year, comparative risks of dying from a specified cause during four weeks of ages under one year, percentage distribution of deaths at various ages under one, death-rates in 1941–47 % of 1911–20, and deaths from specified causes % of deaths from all causes under one. The death-rates for infants have, of course, declined greatly comparing 1911–20 with 1941–47—those for scarlet fever and measles to about a tenth and those for the other diseases to about a quarter of the initial level. Most of them also contribute little to the general I.M.R.; by 1941–47 only whooping cough (1·9%) caused more than 1% of all deaths in infants. Dr. Logan points out that ages of attack of notified infectious diseases have been collected centrally only since 1944, so that there is no available evidence for determining whether the decline in the death-rates among infants since 1911 has been due to reduced prevalence or fatality. With diphtheria, he thinks both have declined; with the other six diseases it is not certain that prevalence among infants has materially declined, whilst fatality almost certainly has, since immunisation plays little part in this age group.

The Annual Dinner of the Society

As previously announced, the Annual Dinner is to be held on Thursday evening, November 24th next, at the Piccadilly Hotel, W.1. The President (Dr. H. C. Maurice Williams) will preside and the immediate Past-President (Prof. R. H. Parry) will support him. The Minister of Health will be the principal among the guests.

Tickets, price 22s. 6d. (including coffee and tips but not wines), should be applied for, with remittance, from the Executive Secretary, as soon as possible. There is no limit to the number which can be accepted on this occasion.

HEART DISEASE IN CHILDREN*

By WILLIAM EVANS, M.D., D.SC., F.R.C.P.
Physician to the Cardiac Department, the London Hospital and the National Heart Hospital.

Nothing can be more important in the practice of medicine than a proper examination of the heart in a child and at the start of life. This examination should have accurate diagnosis as its aim so that unwarranted cardiac invalidism may be avoided on the one hand or, in the case of a diseased heart, that the child should be allocated to a suitable health category in preparation for industry.

In 1940, through the co-operation of Dr. W. A. Bullough and Dr. E. Miles, I was able to start what I will refer to as the Oldchurch Plan, whereby any child found with any sort of murmur or other physical signs which might mean heart disease, during routine school medical examination, was automatically referred for a special cardiovascular examination. The Oldchurch Plan proved a great success, for it enabled 60% of such little patients to be reassured that the heart was healthy and that physical signs connected with it were of the innocent kind.

Unwarranted Cardiac Invalidism

In a practice confined to cardiology I have become aware in recent years of the magnitude of this problem of imposing invalidism on healthy subjects following a misinterpretation of physical signs. It is a disagreeable criticism to aim at the practice of medicine that a young subject with some trivial complaint like palpitation, stitch in the side, or an innocent heart murmur, exposes himself to the risk of a false diagnosis which might commute him to a life of unjustified invalidism, when an escape from such discomfiture would have been possible if he had evaded his doctor and waited for his trivial complaint to pass. That this invalidism is commoner in cardiology than in other departments of medicine is explained by the obscurity of certain physical signs elicited particularly by auscultation, and by the ease with which surmise and conjecture control our views on the mechanism of such signs; in this way dogma is born without data and fact gives way to fantasy. The heart cannot suffer from this miscarriage in diagnosis, but the blow falls heavily on the central nervous system where the damage is often irreparable; it may bring untold misery to a whole family in the form of a livelihood lost, a goal unreached, an ambition ungained. A full realisation of what was happening should draw from us the admission that, apart from healing the sick, we have too often caused the healthy to sicken and have added newer ills to those whose only ailment has been the belief that they were ill.

The need for greater caution in the future against creating doctor-made illness received emphasis from experience of examining healthy members of the community in the several sections which cardiology touches.

Tens of thousands of our school children are condemned each year to unwarranted invalidism, usually because of an incidental or innocent murmur. They are denied healthy games and playtime; they are absent from school for months or years; their re-attendance at school involves transport by a public conveyance, to the personal embarrassment of the children and the financial embarrassment of the taxpayer; they do not even escape compulsory attendance at a special school for those physically defective.

Many thousands of recruits for military service, able-bodied and healthy-hearted young subjects, have been relegated to Grade III or IV and denied the opportunity of serving as combatants in two world wars, all because they exhibited a trivial systolic murmur, and who could estimate fairly the extent of the mental injury wrought them?

Prevention of Invalidism

Enough has been said to emphasise the importance of the problem, and it remains to examine how best to prevent these ills within the specialty and scope of cardiology.

In children there are two common causes for this invalidism:—

1. *Cardiac Enlargement*

A statement that the heart is enlarged should not be given lightly and in the absence of sound supporting evidence, and never with the false reassurance that "there is nothing serious; the heart is only slightly enlarged." Our responsibility here is based on the realisation that an enlarged heart is destined to enter into failure if given time. It is proper to seek the apex beat, but when its place is farther to the left than is usual for it, enlargement of the heart is responsible for only one in four cases; it is the other three that are misleading in diagnosis and in these the shift of the heart, or of the thoracic cage in relation to it, is the outcome of such innocent conditions as a shallow thorax, scoliosis, depression of the sternum, and other forms of asymmetry of the chest wall. We are bound to exclude these benign causes of a shifted apex beat before imposing restrictions on a patient because of cardiac enlargement. To scour our practices for such cases would mean the freeing of countless erstwhile invalids and a lifting of their mental burdens and physical restrictions.

2. *Heart Sounds and Murmurs*

It is from heart sounds and murmurs in children that unwarranted cardiac invalidism springs most readily and the misinterpretation of certain auscultatory signs become a common fault in clinical medicine.

In the case of sounds, a common error is to mistake splitting of the first heart sound, which is a finding in healthy subjects, for the presystolic murmur of mitral stenosis. The mistake is the more readily made when palpation finds a double impulse of the heart beat during systole which gives a false impression of a thrill. The recognition of this innocent auscultatory sign is made from a due regard of its character, "r-rup" instead of "thur-rup," its site at the lower end of the sternum as well as at the apex beat, its greater intensity in the upright than the reclining posture, and the absence of other signs of mitral stenosis.

The other auscultatory sign connected with hearts sounds which is so often quoted in support of organic heart disease, is accentuation of the second sound in the pulmonary area. It is true that in the presence of right heart preponderance, this sound does often become loud, but, since the same could happen in health, little notice should be taken of it. If indifference to this auscultatory sign became customary it would by itself contribute greatly to the reduction of invalidism now caused by an over-zealous regard of its value as a supporting sign of heart disease.

The most common example of sham heart disease at all ages is provided by innocent murmurs in the mitral and pulmonary areas. The clinical signs of mitral disease are important to recognise, but it is of greater moment to learn the hall-mark of an innocent systolic murmur. There are three clinical varieties of the innocent murmur heard near the mitral area which can be identified from a regard of the character of the murmur, the effects upon it of deep inbreathing and posture, and its place in systole.

The *innocent murmur of reclining posture* is blowing in character and is not loud, so that if often disappears on deep inspiration. It is loudest in the reclining posture when a similar murmur appears in the pulmonary area. It is placed in mid-systole; it is common in children and in young subjects, and it is never met with after 40 years of age.

The *innocent parasternal murmur* is blowing or whiffy and loud enough to persist on deep inbreathing; it is loudest in the fourth intercostal space at the left border of the sternum, but, unlike the murmur of ventricular septal defect, it is never accompanied by a thrill. It is placed in mid-systole. Although commoner in young people, it is often met with in older subjects.

The *innocent murmur in late systole* is blowing in character and loud so that it persists on deep inbreathing. The murmur is placed nearer to the second than the first heart sound and for this reason it is easily recognised on clinical auscultation. It occurs at all ages.

To allow a diagnosis of *mitral incompetence* to stand as our interpretation of a mitral systolic murmur is to invite an inac-

* Abridgement of an address to the Refresher Course for School Medical Officers, London, April 5th to 10th, 1949.

curate diagnosis at any time, while to apply it to the murmur just described is to commit a wrong limitless in its injurious effects. It is because of the complacency engendered by this mischievous diagnosis of mitral incompetence that we must quickly forego the term; as long as it is allowed to stay, so long will it prove a disservice to medicine and prove a travesty of diagnosis by clinical auscultation.

Organic Heart Disease in Children

Our knowledge of that scourge among little children, rheumatic fever, is still incomplete, and it will remain so unless we see more of this illness in all its phases and particularly its early period. We shall never enjoy this close grasp of the disease unless notification of it becomes compulsory, and we must strive to bring this about. One of the main problems to be decided is the time when valvulitis set in and whether it came on abruptly during the illness or insidiously some time later. I believe that the former applies, but there is as yet no real proof of this.

A child with a heart murmur, even of the innocent kind, easily falls victim to unwarranted invalidism, and when it is made known that the child suffered at one time from frank rheumatic fever or even a painful limb, its escape from such enforced invalidism is very improbable. Experience in the examination of children has so convinced me of the malinfluence which a past history of rheumatic fever exerts in a case showing a murmur that I am led to make the serious proposal that we must arrive at a diagnosis of the presence or absence of valvular heart disease from a regard of the clinical findings by themselves and without any knowledge of the past history of rheumatic fever; we should have confidence in our objective physical signs and rely less on the history of a past uncertain infection.

When *valvular heart disease* has been discovered in the child it is important to allocate the patient immediately in the appropriate *health category* and to organise education and training for suitable occupation in industry which will demand physical exercise commensurate with the patient's ability, having regard to the cardiac injury. For this purpose every children's hospital should become a school, every ward a classroom, every nurse a teacher, and every little patient a pupil.

Collaboration by those concerned is the great need at this stage, and it concerns patient, parent, school teacher, education authority, labour exchange, employer and cardiologist. The almoner at the cardiac centre is indispensable for recruiting everyone's help to fit the child, handicapped often only slightly by his disease, and crippled mostly by imposition laid on him by the diagnosis, into a suitable occupation.

In regard to physical activities during school years, playtime, healthy games and drill could be permitted, but ambition to excel at games should be discouraged and competitive team games disallowed for the most part.

A word must be said about the management of *congenital heart disease* because the inroad of surgery into this particular branch of medicine has called for a preciseness in diagnosis which has not previously been of great moment; in treatment, too, the more conservative methods of the past are being thwarted and it is time to examine whether this procedure is wholly justified in the several conditions for which surgical treatment is being proposed.

Ligature of a *patent ductus arteriosus* seems a commendable procedure provided we know for certain that spontaneous closure is not a common event in such cases. The operation prevents the advent of bacterial endocarditis which occurs in one-fifth, and heart failure which is also seen in the adult. Above all the operation in experienced hands is not a hazardous venture, and this in itself gives support for the proposition to tie the duct in every case where it is found to be open.

We should encourage surgeons to deal with *coarctation* of the aorta, but I do not think that resection of the stricture is the ideal operation because of the uncertain behaviour of the ringed scar in adult life and especially under the stress of fortuitous hypertension, or residual hypertension from the initial coarctation. The operation is not without serious risks and this has to be offset against the uneventful longevity peculiar to many patients without specific treatment.

We have heard of valvulotomy being carried out in *pulmonary stenosis*. Is it right to add incompetence to stenosis, and joined with the risk of thrombosis and embolism?

What of the creation of an arterior-venous fistula for the blue babies of *Fallot's syndrome*? Many succumb to the operation at the time, some "re-pink" and become more ambulatory, but they face the burden imposed on the heart by the creation of an arterio-venous shunt which under other circumstances is an undesirable lesion necessitating closure.

I invite those present to help to save those children with rheumatic heart disease from becoming social derelicts and to fit them into congenial occupation, and to avoid creating unwarranted invalids and doctor-made illnesses. To this end I exhort you to return to your respective boroughs and counties, and immediately put into operation the "Oldchurch Plan" which would ensure that these two aims on behalf of the children of this country are securely gained.

MACTE NOVA VIRTUTE, PUER[1]*

By Alexander Hutchison, M.D., D.P.H., F.R.F.P.S., D.P.A.,
Deputy Medical Officer of Health, City of Leicester

Shortly after the passing of the Local Government Act of 1929, a new medical officer of health was born, and for some 18 years this new officer was the favourite son of the Ministry of Health, but having reached the mature age of 18 the Ministry decided it was time that she gave birth to a new son, which she did on July 5th, 1948.

The arrival of this new infant was heralded with much *éclat*; so much so, that the youth of 18 felt he was being pushed, once and for all, out into the wilderness. The Ministry made preparations to bestow all the good things that she possessed on this new child and, naturally, the youth of 18, who up until then had had all the good things of life bestowed upon him, felt hurt, if not a little resentful. He was being sent out into the world shorn of many of the things that he had come to regard as his own, and which he felt he should have taken with him, but which I, personally, think were rightly kept in the family and handed down to the new lusty and thriving infant.

Just before July 5th, 1948, on an invitation card to a garden party at the Leicester City Isolation Hospital, was a Latin quotation—*Macte nova virtute, puer, sic itur ad astra*. This message of goodwill and good cheer, sent by the Leicester City Health Department, was intended for the Sheffield Regional Hospital Board, but I think that it should have been sent to every medical officer of health in the country, because it was they who were setting out for pastures new, which offered great hope and scope for new enterprise.

Just before and since the appointed day, there was in general a feeling of despondency among medical officers of health; so much so, that at one time it was almost generally accepted that the end of the medical officer of health was in sight. However, the light still burned, and some felt that all was not lost, as there was still plenty of work to be done. Despite this, the feeling of gloom still persisted among the profession as a whole, and instead of branching out and expanding existing services, encouraging new services, for which there is ample statutory power, many fell back and attempted to hold on to some of the functions they had performed prior to the appointed day.

They made what I think was the mistake of having themselves appointed to local Hospital Management Committees, and one even attained the eminence of being appointed to a Regional Hospital Board. This may have been the correct line to take immediately after the birth of the new service, but I feel that as soon as possible the medical officer of health should relinquish any such appointment he may have in order to devote all his energies and administrative abilities to consolidate his present position, to regroup, to expand and to create new services. I feel that medical officers of health should not seek re-election to Hospital Management Committees, as there are sufficient people with sufficient experience to take

* A paper read to the East Midland Branch, Society of M.O.H.

over these posts. It may be argued that it is necessary for the smooth running of the Health Service that the medical officer of health should be on a Hospital Management Committee, but if he is on one, should he not be on all Management Committees in his area, unless the particular Hospital Management Committee on which he serves embraces all types of illness? There should be a definite liaison committee established between Regional Hospital Boards and local authorities, at which problems affecting both can be discussed. I am aware, of course, that this type of committee is in existence, but do they meet often enough? I think it is wrong that a medical officer of health should have to spend much of his time discussing colour schemes of wards, rates of pay for hospital porters, petty squabbles in the hospital, etc., etc.

The medical officer of health should now have time to look around and consider what alterations are necessary in the set-up of his own department. He should forget that he once administered these hospitals, because they have now passed from his hands for ever. He should now be in a position to make more intimate contact with the people with whom he will be dealing from day to day, *i.e.*, general medical practitioners, and this contact should be made not only at committee level, but at informal meetings with all his fellow brethren.

In a paper like this, it is impossible to go over one by one the duties of the medical officer of health, and point out ways in which each department under his administration could be strengthened, but several of his functions call for special attention.

(1) Food

Under the Food and Drugs Act, the medical officer of health is given extremely wide and exact powers over the preparation, handling and supervision of food, and also over the premises in which this food is dealt with. All of us, however, no matter where we come from, could walk into cafés, restaurants and other eating houses, and find conditions there which are not a credit to our public health service. An answer to this statement, however, is that we have not got enough sanitary inspectors to do the work, but would it not be possible to employ staff who have had domestic science training to undertake this work? Grant you, there is the difficulty of giving these people statutory power of entry, but I feel that if this scheme were put over correctly to the catering trade in general they would accept it, and for those who would not there is always the sanitary inspector, who could inspect the premises and obtain the necessary results. If we look for a moment at the report of the Ministry of Health for the year ending March 31st, 1947, we find the following statement: "Exclusive of 550 outbreaks of food poisoning caused by *salmonellae*, 43 outbreaks were reported, as compared with 45 in 1945." This does not represent a true picture of what is happening throughout the country. We know that every day there are many people suffering from food poisoning, but it is only in those outbreaks where a large number are involved that the incident is reported and the medical officer of health is called in.

I feel that there has not been sufficient notice taken of the fact that food poisoning is a notifiable disease under the Food and Drugs Act, 1939. Fortunately, the Ministry of Health has issued a new circular[8] asking medical officers of health to bring this fact to the notice of general practitioners, and I am sure that much good will result. The medical officer of health should, by publicity campaigns, keep the public informed that clean food and good health go hand in hand together, and that he would welcome their co-operation to attain this end. How many medical officers of health have really active clean food campaigns going on in their district? Sporadic lectures—yes, but continuous campaigns—no.

At present we have a Ministry of Food, which has many wide and varied ramifications, but in the future, will there always be a Ministry of Food responsible for bulk buying, and so on? If this aspect of the Ministry of Food disappears, then much of the work could be reabsorbed into the field of public health and of the Ministry of Health, because food is the basis of all good health. The preparation and circumstances under which food is eaten, the guidance of what is correct diet, and research in the fields of nutrition are surely public health functions.

(2) Soil Fertility

This is a field of public health in which medical officers as a whole have not had much experience, but on a long-term policy, the results of their labours would more than reward the energy they would expend in this most interesting field.

(3) Epidemiology

The medical officer of health's training is directed towards the science of epidemiology, and since the appointment of the first medical officer of health in 1847, there can be no doubt whatsoever that the medical officer of health has done an excellent job. By his immediate and skilful investigation of outbreaks of infectious disease, he has greatly reduced the incidence of all infectious diseases and saved countless lives; but now a new service has grown up, and is still growing—the Public Health Laboratory Service, who state, in their own words, that this service "is available and always prepared to participate actively in the investigation of ourbreaks of infectious disease in the area which it serves."[9] Is this offer really necessary? The officers of this new service have had little or no training in epidemiology, their training being directed mainly towards the study of bacteria in laboratories.

The medical officer of health should not require for his field work, except in extreme emergencies, the services of any outside organisation. I know that criticism will be levelled, because everyone advocates that we should pool our knowledge and work as a team. In my opinion, if a medical officer of health wishes further advice and help, he should consult one of his colleagues, whose training has been in epidemiology, rather than ask a medical officer whose training has been directed specially towards the examination of bacteria. Bacteria do not change their habits very much, and although many of them have changed their name since we first heard of them, they still behave and act as they did in days gone by. There is, however, no harm in a medical officer of health taking a refresher course in bacteriology, but to resort to calling in an outside service whenever he is in difficulties is a policy that will only lead in the end to this most interesting branch of his work being taken out of his hands.

(4) Health Centres

Few medical officers have really got down to the problem of supplying Health Centres. It is true there has been much discussion, but no provision. Health centres have not been provided, partly because the medical officer of health has not had time to get down to the details necessary for the provision of health centres, because of their low priority in the building scheme, and because of the necessity to limit expenditure. Why should this service, which, in my opinion, is of paramount importance, be a step-child of the new health service?

In most cases, the health centre problem is only at the discussion stage, but I feel that now is the time actively to pursue the provision of these centres. The medical officer of health should be actively pressing forward for the provision of these centres, because they will undoubtedly be one of the most important services which he will have to administer. It is in the administration of these centres that all the administrative ability of the medical officer will be brought into play.

Many plans have been put forward on the structural requisites of health centres, and I feel that from a combination of the many suggestions put forward, excellent centres will arise, but I should welcome the reactions of my colleagues to the suggestion that, instead of taking refresher courses in public health, a medical officer should ask for three months' leave of absence, during which he himself should undertake general practice, in order to become conversant with the everyday difficulties of his fellow brethren. He would then have a practical knowledge of their difficulties, their hopes and their desires. Indeed, I will go further and suggest that no medical

officer of health of the future should be appointed unless he has done at least one year in general practice.

At the health centre there should be every facility for medical research, and the general practitioners should have every facility to carry out whatever research they wish. To this end, there should be sufficient social workers attached to each health centre, and these social workers should have the training outlined by Davies and Brockington.[4] In any social investigations, the medical officer of health could play a prominent part as friend, guide and advisor to any general practitioner undertaking this work. I think, however, it is a great mistake for too great an emphasis to be placed on statistics, because there is every chance that medical officers of health may be relegated to be back-room boys to dabble with figures, which, in themselves, are most interesting, but which do not satisfy the insatiable appetite of any active medical officer in his desire to improve the health of the community.

All social work regarding patients should be carried out from individual centres, and complete records of all visits should be kept and filed. A sound-proof room should be erected in all the larger centres, where instructional films can be shown without disturbing the peace and harmony of the centre. To encourage the general practitioners, and to remind them what can be done, there should be a portrait of Sir James McKenzie in every health centre.

(5) Occupational Health

Laidlaw[5], in a paper in the *Medical Officer* of April 23rd, has put forward the suggestion that the local authorities should offer the smaller factories an occupational health service. He is of the opinion that the local authority should apply to these smaller factories, on a part-time basis, the services of a medical officer, on the staff of the Public Health Department. He mentioned that such an employee would not be regarded with suspicion by the employees or the management, and that, in addition, he would be an impartial investigator, who would have access to all branches of the public health department and to all departments of the local authority.

Laidlaw advocated the inclusion on the staff of every major health authority one medical officer who has been specially trained in industrial health, in order that this deficiency in the environmental health service can be made good. We must all agree with Laidlaw, because, as we all know, there are many small factories carried on in all sorts of unconsidered nooks and crannies. It is in these small factories that much could be done to improve the health of the worker. If the hygiene of these factories were energetically tackled, much illness and suffering could be eliminated.

I feel that the course advocated by Laidlaw is sound, and that if the medical officer of health did offer an occupational health service for these smaller factories, it would in turn relieve the general practitioners of much of their everyday humdrum work.

(6) Ambulance Service

From time to time, many medical officers of health have thought that the Ministry of Health could have been more positive in their advice to local authorities, and in the next two aspects of the work of the medical officer which I propose to deal with, this feeling is brought out into relief. In their circular of April, 1947 (66/47), the Ministry left it to local authorities to decide whether the ambulance service should be combined with the fire service, and who should also run this service. If ever there was a health service, surely it is the ambulance service. The result of this circular was that up and down the country different methods of administration of ambulance services are in operation, and I believe that there is confusion and some heartbreaks over the rates of pay of some of these employees. In my opinion, the Ministry should have indicated clearly that it was the duty of the health committee to organise and run the ambulance service, and if this was so, much confusion would have been eliminated.

(7) Welfare

Again the Ministry, in an unfortunate circular of April, 1948 (70/48), left it to the local authorities to decide who should administer Part III of the National Assistance Act. The result is, there are various different systems operating throughout the country, and surely no one can deny that the specialised services for the blind, deaf, dumb and other handicapped persons, the provision of residential accommodation for the aged, etc., are the duty of the medical officer of health. Many of these people require constant supervision. In the future, are we going to have health visitors employed by the health committee and others employed by a separate welfare committee? Surely the work should be under one authority —the M.O.H. I feel that he should be responsible not only for all duties under Part III of the National Assistance Act, but also for certain duties under Part IV of the same Act, such as registration of old peoples' homes, etc.

(8) Housing

The medical officer of health should take a far more active interest in housing conditions, and in their relation to health, than he does at the present moment. In large county areas and large county boroughs, there are housing departments with their own administrative officers and welfare officers, but, although they work in quite close co-operation with the medical officer of health, they are not striving towards the same goal.

Much could be done by the health visitors, under the medical officer of health, making closer investigations into the relationship of disease to housing, and the relationship of social misfits to housing, etc., but this is extremely difficult where the housing department employ welfare officers of their own; nor, indeed, is it desirable that the work of the welfare officers of the housing department be overlapped by health visitors from the health department. How many medical officers of health have really tackled the problem of why a woman keeps an untidy or dirty house?

These are only some of the duties of the medical officer of health, which I think require his immediate attention. All medical officers of health seem to be working at six's and seven's; some of them being in charge of some aspects of public health and others not. I know that we have our central organisation, but is it active enough, or should we, like the Conservatives, have a ginger group to see that our desires are pressed home to the fullest?

I feel that by some means or other there should be closer contact between us and the Ministry of Health, and if this were so, some of the unfortunate circulars, and even Acts, which have been passed would not have seen the light of day.

REFERENCES

[1]VIRGIL. Aeneid IX, 641.

[2]MINISTRY OF HEALTH Memo, 188/Med. Revised 1949. H.M. Stationery Office.

[3]*Mthly Bull. Min. Hlth & P.H. Lab. Ser.* (October, 1948), 220.

[4]DAVIES, I. G., and BROCKINGTON, F. (1949.) *Public Health*, **62**, 144.

[5]LAIDLAW, S. I. A. (1949.) *Med. Off.*, **81**, 173.

Central Council for Health Education: New Appointments

Dr. L. J. H. Burton becomes deputy to Dr. Robert Sutherland, the Medical Adviser and Secretary. Before the war Dr. Burton was assistant pathologist to the Central Middlesex Hospital. After war service with the R.A.M.C. in Italy and Africa and a period as a P.O.W., he was M.O. at the Guards' Depot, Caterham, and recently assistant M.O.H., Middlesex.

Dr. Anne F. Burgess, L.D.S., becomes assistant to Dr. Sutherland. Before going out to Malaya in 1935 she was a school D.O. at Ilford. In Malaya she did both dental duties and medical practice and her last appointment was as school M.O. for the State of Selangor.

Mr. William John Wheeler has been appointed educational psychologist. This year he became psychological Fellow (child guidance) of the Tavistock Clinic.

Mr. C. A. P. Noseworthy, of University College, South Wales, formerly senior lecturer at Cardiff Technical College, becomes Education Officer.

The Council's exhibitions are to be organised by Mr. George William Grosse, who was senior executive exhibitions officer at the Central Office of Information, and Mr. Bernard B. Sykes, formerly press and publications officer to the National Coal Board, will be responsible for publications and press relations.

LOCAL AUTHORITIES AND TUBERCULOSIS

A joint meeting of the Society of Medical Officers of Health and of the National Association for the Prevention of Tuberculosis held in the Great Hall of B.M.A. House on Thursday, September 15th, attracted a large attendance of some 130. In addition to members of the Society and Association, representatives of health visitors, almoners and social workers were present, as were those of the Ministry of Labour's headquarters and disablement and resettlement department, of the National Assistance Board and of the National Association of Home Help Organisers.

Prof. R. H. PARRY (President of the Society) was in the chair and was supported by Sir Robert Young (vice-chairman, N.A.P.T.). Prof. Parry opened the meeting by expressing gratitude to the N.A.P.T. and its Secretary-General (Dr. Harley Williams) for initiating this opportunity of exchanging views on the arrangements made by local health authorities for prevention, care and after-care of tuberculosis under section 28 of the National Health Service Act 1946. He said that after the earthquake of July 5th, 1948, they were just beginning to find their feet, and it was a most appropriate time for reviewing the position in regard to the biggest public health problem of the day—tuberculosis. They knew that tuberculosis was something more than clinical treatment. The first speaker, Sir Allen Daley, was so well known to all that he needed no introduction.

Sir ALLEN DALEY (C.M.O.H., London) said that it had been wise to keep the discussion off the hospital aspects of the disease. Real prevention of tuberculosis was founded on conditions of life, *viz.*, housing, general nutrition and hygiene. Many years ago he had conducted an investigation to see whether there was an inverse relation between the decline in tuberculosis and the rate of expenditure on hospital and dispensary services. No such relation had been discovered. He thought it important therefore that the public health service should concentrate on the basic conditions which affected the disease and keep a close watch especially on the general nutrition of the people. The second aim of prevention was the isolation and removal of the patient and source of infection. Legal powers under the Assistance Act, and elsewhere, for compulsory removal to an institution, were not of much practical value in cases of tuberculosis. The chronic ambulant infectious case who was homeless presented a problem; L.H.A.s should consider provision of special hostels although these would be difficult places to manage and control. Alternatively people living in houses with surplus accommodation might be persuaded to give rooms to such ambulant cases. Children in contact with open tuberculosis should be boarded out on the Granchet system. Some 300 London children were boarded out on this ground, about half in residential nurseries and schools.

Sir Allen considered that mass-radiography was best placed under the control of regional hospital boards provided that the L.H.A. advised on its best use. The payment for transport to the unit might be a biggish item for the L.H.A. He believed that there should be provided *x*-ray examination of all persons in close contact with groups of children. They might be surprised to learn that there were 30,000 such people in London. L.H.A.s would have to pay regional boards for this work and it might indeed be cheaper if they provided and ran their own *x*-ray plants.

Another essential in prevention was good health visiting in association with the chest physician. Regarding B.C.G. he said that if it was necessary to segregate children from infection for six weeks before and after vaccination, were they to be kept in camp schools or special hostels? It must be remembered that education must continue. Perhaps open-air schools and holiday homes would be the answer.

Turning to the care of the disease, Sir Allen said that, where the tuberculous could not obtain sanatorium treatment, they must receive home nursing and home help. The L.H.A. might also consider providing a meals service, especially where the patient was the housewife. Transport to and from attendances for A.P. refills was another need.

After-care requirements he defined as:—

(*a*) Continued supervision of and finding jobs for the recovered cases. Here the relations of almoners and care committees with the L.H.A. were important.

(*b*) Remploy factories' and night sanatoria for chronic ambulant cases.

(*c*) Care of semi-bedfast and dying cases, which were the most infectious. In these cases a special effort must be made to remove child contacts.

In general they must try to define the responsibilities of local sanitary authorities (under the Tuberculosis Regulations, 1930) of local health authorities and of regional hospital boards. The service must not be allowed to drift into being a purely curative one. Even if the hospitals were centres of treatment, they must have chest clinics as their outposts.

Dr. G. W. H. TOWNSEND (C.M.O.H., Buckinghamshire) dealt with problems peculiar to counties and rural areas. The 1930 Tuberculosis Regulations still gave big powers to local sanitary authorities; for instance, regulation 12 read:—

"12. For the purpose of these regulations:—

(1) A local authority on the advice of their medical officer of health may supply all such medical or other assistance, and all such facilities and articles as may reasonably be required for the detection of tuberculosis, for preventing the spread of infection and for removing conditions favourable to infection, and for that purpose may appoint such officers, do such acts and make such arrangements as may be necessary:

Provided that nothing in this paragraph contained shall be deemed to authorise a local authority to take any of the measures herein mentioned at any institution other than one belonging to the local authority.

(2) A local authority, on the advice of their medical officer of health, may provide and publish or distribute suitable summaries of information and instruction respecting tuberculosis, and the precautions to be taken against the spread of infection from that disease."

In his experience the district councils had made little use of their powers and the county councils had had to develop a preventive service parallel with their curative service. Would the L.H.A.s do any better now that they had lost their treatment functions and retained only those of section 28?

Neither the chest physician nor the L.H.A. could do effective preventive work without the other. The chest physician must have adequate time for preventive work. The R.H.B. was responsible for the actual examination of contacts, the L.H.A. for seeing that contacts were traced. The source of infection should be the first target and the chest physician should be responsible for this as well as contact-tracing. There must be free exchange of information between M.O.H. and C.P.; any statistical results must be as quickly transmitted to the C.P.

He thought that welfare work confined to tuberculosis was time-consuming and should be combined with that for other conditions. Good co-operation between health visitor and welfare worker was essential. He was concerned that extra food allowed for the tuberculous should reach the right destination. Its preparation was important; was there a place for a dietitian on the health department staff?

The tuberculosis service might take a leaf from the M. & C.W. book. Mothers at welfare centres waiting to see the doctor were learning all the time by lecture, film or leaflet. At the tuberculosis dispensary waiting was just waiting and here was an opportunity for health education on welfare centre lines. Occupational therapists might be based on such area centres as old peoples' homes.

Generally speaking, experts must be properly dovetailed and he advocated the use of these people over the whole range of public health problems rather than treating tuberculosis as an isolated condition.

Dr. STUART LAIDLAW (M.O.H., City of Glasgow) said that more evidence was wanted on the relation of overcrowding and tuberculosis. In Glasgow they had found that the contact rate was twice as bad in one- and two-room houses as in three- and four-room. They had not used the powers of removal under the National Assistance Act since the psychological effect was bad.

He disagreed with the attachment of the chest physician to the regional hospital board. The effect had been concentration on the curative and clinical aspects and the domiciliary interest had waned. There was in Glasgow a waiting list for sanatorium beds of 1,660 but no chance of admission unless the case was of special clinical interest. The M.O.H. had no power to enforce admission, so a day-to-day battle was in progress to get cases away from dangerous home conditions.

He thought that the L.H.A. should use B.C.G. through its own staff and not accept a second-hand service from an overworked tuberculosis staff. The L.H.A. should also regain direct control of mass radiography as another preventive service. Segregation of children for B.C.G. vaccination was being arranged and home helps for tuberculosis cases were volunteering from amongst the relatives if they could be paid at the usual rates.

Referring to Sir Allen's point about hostel accommodation for ambulant cases, Dr. Laidlaw described how an empty ward in a tuberculosis hospital had been reopened as a hostel for 60 discharged cases who shared the catering and domestic work. Lastly, he urged that the tuberculosis health visitor was all-important.

Dr. W. ALCOCK (M.O.H., Burton-on-Trent C.B.) speculated whether the decline in tuberculosis mortality was due to environmental improvements of the past century or to a secular variation in virulence such as one saw in other infectious diseases. It was an inevitable conclusion that environmental and social betterment was fully responsible in this instance. He thought, however, that the factors of resistance, susceptibility and acquirement of immunity still required much investigation but suggested that when employment was high, housing good and leisure-time wisely spent, tuberculosis

would further decline. The results of B.C.G. trials in this country would be eagerly awaited.

Regarding housing priority for the tuberculous, Dr. Alcock said 20 points were essential to get a house and his department could not give more than five on medical grounds. Tuberculosis should have an absolute claim for rehousing outside the points scheme.

M.O.H.s should press for the provision of aids and supplementary foods to tuberculosis contacts as well as to active cases. The best hope of controlling the spread of the disease lay in raising the resistance of (*a*) contacts with active cases, (*b*) all young persons up to 25 years, (*c*) expectant and nursing mothers and (*d*) other special categories liable to contract tuberculosis. Additional costs on behalf of prevention would be well worth while.

Pressing for earlier detection of cases, he urged *x*-ray and re-*x*-ray of all entrants to industry and of all entrants to all the Services and to all Universities. He was glad to see that regional boards had directed periodical examination of nurses. He reminded them of Dr. Lissant Cox's aphorism, "Seek, find, isolate and treat the sputum-positive case."

Dr. K. NEVILLE IRVINE (Henley-on-Thames) author of the recent book "B.C.G. Vaccination in Theory and Practice," said he would confine his remarks to three questions:—

(1) Should B.C.G. be given to selected cases or *en masse*? In our resistant community the Ministry of Health had decided on selection.

(2) Why was segregation required for six weeks before and after vaccination? It was wise to observe this rule in the interests of the prestige of this new procedure. If pre-segregation was impossible, they could vaccinate in the pre-allergic state. Likewise, if the Mantoux test six weeks after vaccination was not positive, there should be another test at ten weeks before re-vaccination; some people were slower than others in conversion. If re-vaccinating after ten weeks he advised a double dose. Failure to segregate after the first vaccination did no harm, but some cases might contract the disease before immunity was established thus damaging the reputation of this form of protection. But he would rather see B.C.G. vaccination done without any segregation than not done at all. A dose of 100 tuberculin units should be employed as a criterion of a negative reactor for vaccination.

(3) Was intracutaneous injection preferable to multiple puncture? This had been settled by the Ministry's decision to use the Copenhagen serum, which was specially prepared for intracutaneous injection. The dose should be doubled for newborn infants.

Vaccinees should be warned about the papule which might appear after two or three weeks and sometimes broke down to an oozing ulcer. Ultra-violet light cleared up such persistent ulcers with dramatic speed. Very rarely there might be a glandular ulcer—treatment simple aspiration.

The thing to put over was that B.C.G. treatment was never dangerous and the after-effect never progressed but healed.

Speaking of the groups to be selected, Dr. Irvine suggested that Mantoux-negative diabetics should be included as should Mantoux negatives in tuberculosis families, especially those in contact with streptomycin-resistant cases.

His final advice was to beware of over-propaganda, to warn about chronic lesions which might appear, and not to offer B.C.G. as complete protection.

Miss ANNE TOPLEY (Care Almoner Surrey C.C.) spoke from her experience of seeing patients both in the chest clinics and in their homes. The local mechanism for diagnosing the social needs of the patient must be good and the L.H.A. must be able to provide an effective and adjustable scheme. The social worker must be one of the chest clinic's team, of which the health visitor had the most important contact with the homes of patients. The L.H.A.'s scheme must provide good co-operation between the health department and other departments and organisations. She thought that extra nourishment to be effective should be on a more generous scale and suggested that prefabricated rooms would be better than garden shelters for all-the-year-round use. Boarding out of child contacts might be assisted by financial contributions from the families themselves. Holiday schemes to increase resistance could be subsidised by care committees. In her experience home helps would volunteer to assist the tuberculous. She regarded after-care and rehabilitation as the L.H.A.'s prime responsibility; the latter should start as soon as the case was diagnosed. Referring to Dr. Townsend's view about all-purpose social workers, she said that the nine almoners in Surrey concentrated on tuberculosis and did not lose much time travelling from case to case. Lastly, in reply to an enquiry by Dr. Laidlaw, the great advantage of care committees was that they could provide help in cash to the patient himself.

Prof. PARRY, declaring the subject open to general discussion, said how pleased he was at this opportunity of meeting with the N.A.P.T. and with Sir Robert Young, under whom he had been a student at the Middlesex Hospital.

Dr. A. S. HEBBLETHWAITE (Sunderland C.B.) asked if incidence were greatly declining, because it was not so amongst the children of his town. It was impossible to isolate an open case in a household and he enquired if any L.H.A. was providing a preventorium for isolation of child contacts.

Sir ALLEN DALEY replied that the L.C.C. were using private homes through the I.C.A.A, institutions run by the Children's Committee and open-air residential schools. Tuberculosis mortality was falling slowly but morbidity was rising.

Dr. R. L. MIDGLEY (M.S. Hawkmoor Sanatorium) welcomed a suggestion by Dr. Irvine that the chronic advanced case be put temporarily in the sanatorium whilst his family were being given a course in B.C.G. The case could subsequently be sent home without danger to his family and thus release the sanatorium bed for another case.

Dr. D. H. GEFFEN (M.O.H., St. Pancras Met.B.) regretted Dr. Townsend's reflections on local sanitary authorities (Dr. Townsend replied that he was speaking from rural areas not of urban) and hoped that L.S.A.s and L.H.A.s would co-operate effectively. For one thing, L.S.A.s were still important housing authorities. The administrative difficulty of segregating before and after B.C.G. vaccination was overwhelming in London. The risks from other infections of bringing together very young infants far outweighed the risk of contracting tuberculosis. Were not school leavers a good class for B.C.G. protection?

Dr. V. F. SOOTHILL (M.O.H., Norwich C.B.) thought that the old lesson of cleanliness was still the best preventive teaching even in bad housing conditions. He asked how far was the search for contacts to be pursued. It should go beyond the immediate household circle, say to older married children who had moved elsewhere.

Dr. HARLEY WILLIAMS (Secretary-General, N.A.P.T.), referring to the general statistics of tuberculosis, said that both incidence and mortality were increasing in Scotland and perhaps in the northern half of England as far as the Trent. Of care committees he said that local circumstances were not always favourable but on the whole they did excellent work. They had obout 140 affiliated cure committees throughout the country.

Dr. T. M. CLAYTON (M.O.H., Coventry C.B.) suggested eligibility for B.C.G. vaccination for home helps working in tuberculous households and described a mobile meals service for the sick recently started in Coventry.

Dr. J. C. SLEIGH (M.O.H., St. Albans), speaking of getting home helps to go to tuberculous cases, said that this should be a free service wherever any financial worry might be caused. His Council had agreed to give absolute housing priority for the tuberculous where he so advised.

Mrs. RICHIE (National Association of Home Help Organisers) thought that abuses might arise from the employment of relatives as home helps, but payment of the actual time spent on home help work could be arranged. If home helps were asked to go to tuberculous households they should be advised of the necessary precautions. She hoped that M.O.H.s would give a personal talk to their home helps to give them the feeling of being part of the "health team."

Dr. J. E. GEDDES (Chief Chest Physician, Birmingham Region), in a brief summing up, disagreed with Dr. Laidlaw's view about the outlook of chest physicians which would create barriers instead of integrating the hospital and preventative services. He thought also that B.C.G. vaccination must be carried out by chest physicians in collaboration with health departments.

Sir ROBERT YOUNG expressed appreciation of the Chairmanship of Prof. Parry. The fact that the meeting was so well attended by all points of view was a mark of the collaboration between official and voluntary workers.

Finally, Prof. PARRY thanked the N.A.P.T., and especially Dr. Harley Williams, for their initiative in organising this meeting and for kindly providing hospitality at its close.

County District M.O.H. Refresher Course

All available places for the course to be held on November 25th and 26th have now been taken.

PROGRAMME

Friday, November 25th (Hastings Hall, B.M.A. House):—

2 p.m.—Opening Address—Dr. H. L. Barker (President, County District Group).

2.30 p.m.— Housing on Medical Grounds—Dr. E. B. Argles.

4.15 p.m.—Link between Environmental and Personal Health Services: Dr. W. S. Walton.

8 p.m.—Problems of New Housing Estates: Dr. F. G. Brown, Mr. Stewart Swift and Miss A. E. Agate.

Saturday, November 26th (London School of Hygiene, Keppel Street, W.C.1):—

10 a.m.—Recent Advances in Control of Infectious Diseases: Dr. Wm. Gunn.

11.45 a.m.—Food Poisoning: Prof. Robert Cruickshank.

2.30 p.m.—The Future of Health Education: Dr. Robert Sutherland.

3.45 p.m.—Vital Statistics: Dr. D. D. Reid.

OBITUARY

JAMES FERGUSON, C.B.E., B.A., M.B. (R.U.I.), D.P.H.

The death at St. Hilier Hospital on August 27th of Dr. James Ferguson, for 17 years County Medical Officer for Surrey, has taken away another of the distinguished Ulstermen who have contributed so much to English public health. He was born in County Antrim in 1879 and went from the Royal Academical Institution, Belfast, to Queen's College, Belfast, as a foundation scholar in classics. He proceeded as far as an Honours Degree in Classics in 1902 with the intention of taking up a career as a civil servant or schoolmaster. He then turned to medicine and qualified in 1908. He fortunately had a bent for the preventive field and took the D.P.H. (MANCH.) in 1914. He was an assistant medical officer in Lancashire under that great chief, Dr. J. J. Butterworth, whose chief assistant he eventually became. Thence, in 1929, he was appointed Medical Officer of Health and School Medical Officer for Surrey, where Prof. Hope was temporarily filling the vacancy caused by the retirement of Dr. Joseph Cates.

Dr. Ferguson took up duty on the eve of the great transfer of poor law hospitals which his county council, on his advice, seized as a great opportunity for developing one of the finest local authority hospital services in the country. The hospital in which he died is itself a tribute to his planning and it is gratifying to know that the nurses' home there is called Ferguson House. His interest in the welfare of the blind and partially sighted led to his appointment to the Departmental Committee on Partially Sighted Children (1932–34), and to the Ministry of Health's Prevention of Blindness Committee. His services were called for on many other committees, *viz.*, those on the Cost of Hospitals and other Public Buildings (1933–38), the Minister's Tuberculosis and Nursing Advisory Committees, the Preventive Medicine Committee of the M.R.C. and the Medical Advisory Council of the Nuffield Trust and Foundation. He was a good co-operator with voluntary agencies and voluntary hospitals. He was appointed King s Honorary Physician (1941–44) and when he retired from Surrey in 1946 he received the C.3.E., ostensibly for work in civil defence and the casualty services, but we should like to think also as a recognition of his general work for the public health.

Dr. Ferguson was well known to many of his colleagues, by whom he was always much liked for his charm of manner and quiet courtesy. He served many years on the Council of the Society, and he represented the Society for a long period up to the time of his death on the Joint Tuberculosis Council.

His services were too valuable to be lost on retirement and the Ministry of Health took him on the medical staff as a principal medical officer where he continued until his death, thus keeping up contacts with many old friends.

He was a member of the Society from 1917.

We extend our sincere sympathy to his widow and daughter.

WILLIAM GEORGE WILLOUGHBY, M.D. (LOND.), D.P.H.

In the recent death at the age of 83 of Dr. W. G. Willoughby, formerly Medical Officer of Health for Eastbourne, the Society has lost its senior Past-President, for he held that office as long ago as the session 1910–11, two years before the presidency of Prof. E. W. Hope, who still happily survives. He also held the distinction of being the only whole-time medical officer of health who has been elected as President of the British Medical Association, an honour conferred on him by his colleagues when the Association held its annual meeting in Eastbourne in 1930, and carried out with distinction.

He was born in Devon and took his medical training at St. Bartholomew's Hospital, where he qualified in 1888. His younger brother, the late W. M. Willoughby (afterwards M.O.H., City of London), followed him at Bart.'s. After resident posts and study in Vienna, W. G. Willoughby was appointed Medical Officer of Health Eastbourne in 1893, and remained there for the rest of his professional life until his retirement in 1939, when his length of service exceeded that of any other colleague in a major health authority. He had thus seen both Eastbourne itself and its health services grow and multiply and none knew more of the particular public health problems of a rapidly growing seaside resort. His only period of absence from Eastbourne was in the 1914–18 war when he served in Egypt and Macedonia, finishing up as A.D.M.S. (San.) in the 12th Corps.

Dr. Willoughby was always an active member of the Society, which he joined in 1895, but in his latter years he was still more so in the B.M.A., where he was a member of Council and of the Public Health Committee between 1931 and his retirement. Even since the last war he attended at professional meetings and one recalls his appearing as hale as ever at the Eastbourne meeting of the County Borough Group of the Society in 1946. He had also been a president of the Medical Officers of Schools Association.

He was a gentleman of the old school, and his kindliness, modesty and quiet wisdom will be long remembered by the older generation in the Society. The Willoughbys, W. G. and W. M., were one of the distinguished pairs of brothers which have so often appeared in the public health service, and in this case the next generation is still active in the person of Dr. H. M. Willoughby (Dep. M.O.H., Port of London), the son of W. M.

BOOK REVIEW

Public Health in the World To-Day. Edited by Brig.-Gen. JAMES STEVEN SIMMONS, Dean and Professor of Public Health, Harvard School of Public Health, with a foreword by JAMES BRYANT CONANT, President of Harvard University. Pp. 332. $5. Harvard University Press, 1949.

This is a remarkable and very valuable book. Dean Simmons conceived the idea of inviting, during the 1947–48 session of the Harvard School of Public Health, a number of distinguished guest speakers to supplement the regular instruction. They presented papers at meetings which were a series of "public health forums." The book contains the opening papers.

Dean Simmons gave the introductory address himself and based it on the bus journey of Mr. Eugene LeBar from Mexico to New York City. He developed smallpox while on the journey and he died of it nine days after his arrival in New York. Several million New Yorkers were vaccinated in the scare which followed. General Simmons then develops the theme that "human security is essential to peace and the most promising approach to security lies in the development of better physical and mental health among all the peoples of the earth. He asks the questions :—

"(i) What are the objectives of public health ?
(ii) What is the present status of world health ?
(iii) What advances have been made toward improvement of health ?
(iv) What additional improvement can be made in the future ? "

He himself and the writers of the other papers provide some of the answers.

The writers represent a galaxy of talent and include the foremost names in American Public Health. Those best known on this side of the Atlantic are : C.-E. A. Winslow (The Evolution of Public Health and Its Objectives) ; Reginald M. Atwater (Public Health becomes a Profession) ; Lowell J. Reed (The Statistical Evaluation of Medical-Care Needs) ; Rolla Eugene Dyer (The Research Programme of the United States Public Health Service) ; Paul R. Hawley (The Veterans Administration Medical Program and the Public Health of the Country) ; Alice Hamilton (From a Pioneer in the Poisonous Trades) ; Martha M. Eliot (The Child in World Health and Social Welfare) ; Louis I. Dublin (Public Health and the Diseases of Old Age) ; Alphonse Raymond Dochez (The Bearing of Investigations of Acute Respiratory Infection on Public Health) ; and James A. Doull (Nations United for Health).

Prof. Winslow stresses the importance of housing and the mental health programme. Dr. Atwater states that there were only 40 applicants for over 300 vacancies for medical positions in the Public Health Service in his country. Dr. Lowell J. Reed gives a fascinating account of the origin and development of the medical care programme of Baltimore City and describes a five-year survey of 1,500 families in that City. Gen. Hawley explains the excellent provision made for the tuberculous ex-Serviceman, and describes the follow-up programme to try to prevent the late manifestations of syphilis in World War II veterans. There is a strong psychiatric section in the Veterans Administration. Dr. Martha Eliot gives a vivid account of the condition of the children as she found them in the countries of Europe which had suffered most from the war. She emphasises the need for a new preventive mental health service for children and their parents. Dr. Doull describes the birth of the World Health Organisation, in which he himself took an intimate part.

Among other writers, George F. Lull (Medical Education and its relation to Public Health) mentions that a Committee of the Association of American Medical Colleges have recommended that each medical school should have a separate department of preventive medicine and public health, with a full-time head. Joseph W. Mountin (The History and Functions of the United States Public Health Service) states that over 200 commissioned officers of the Federal Public Health Service (chiefly physicians, nurses, engineers and sanitarians) are assigned to assist State and local health departments, university colleges and schools of nursing. Karl Z. Morgan (New Public Health Problems of the Atomic Era) deals with a new subject and describes the work of the Health Physics Division of the Oak Ridge National Laboratory.

In the foreword, President Conant advocates the development of preventive medicine because it is economically impossible " to train enough professionals to keep all the people well by curing disease."

The book is strongly recommended to British readers who desire to keep abreast of current American thought and practice. The only criticism is that there is no index.

SOCIETY OF MEDICAL OFFICERS OF HEALTH

NOTICES

ORDINARY MEETING

Notice is hereby given that an Ordinary Meeting of the Society will be held in the Hastings Hall, Tavistock House, London, W.C.1, on Thursday, October 20th, 1949, at 5.30 p.m.

1. Minutes.
2. Correspondence.
3. Installation of H. C. Maurice Williams, O.B.E., M.R.C.S., L.R.C.P., D.P.H., as President of the Society, 1949–50.
4. Vote of thanks to the retiring President (Prof. R. H. Parry).
5. Election of Fellows (see list below).
6. Nomination of candidates for election.
7. Election of fully-paid Life Fellows on the recommendation of the Council and their Branches :—

Home Counties Branch.—Dr. W. A. Bullough (formerly C.M.O.H., Essex C.C.). Joined Society 1916.

Southern Branch.—Dr. A. E. Druitt (formerly A.C.M.O.H., Hants C.C.). Joined Society 1923.

Welsh Branch.—Dr. R. H. Tighe (formerly M.O.H., Swansea C.B.). Joined Society 1920.

8. Presidential Address by Dr. H. C. Maurice Williams, O.B.E., entitled "Bridging the Gap", to be followed by discussion.

By Order,
G. L. C. ELLISTON,
Executive Secretary.

REPORTS

ORDINARY MEETING

An ordinary meeting of the Society was held in the Great Hall, B.M.A. House, on Thursday, September 15th, 1949, at 2.30 p.m., preceding the joint meeting with the National Association for the Prevention of Tuberculosis, reported on another page. The President (Prof. R. H. Parry) was in the chair and about 100 members were in attendance.

After confirmation of the minutes of the last ordinary meeting and signature by the chairman, the following were elected to fully-paid Life Membership of the Society on the recommendation of the Council and their Branches :—

East Anglian Branch.—Dr. J. W. McIntosh (formerly M.O.H. & S.M.O., King's Lynn) ; joined Society 1920.

Southern Branch.—Dr. G. A. C. Gordon (formerly Asst. M.O.H., Dover and African Medical Service) ; joined Society 1921.

Home Counties Branch.—Dr. P. N. Cave (formerly M.O.H., West Kent U.D.) ; joined Society 1916.

Midland Branch.—Dr. G. N. Anderson (formerly Dep. S.M.O. and Senior Asst. M.O., Staffordshire) : joined Society 1918. Dr. W. D. Carruthers (formerly County M.O.H., Staffordshire) ; joined Society 1910. Dr. H. G. N. Henry (formerly Bacteriologist, Birmingham) ; joined Society 1920. Dr. Stephen Rowland (formerly M.O.H., Northampton) ; joined Society 1920.

Northern Branch.—Dr. Elizabeth Niel (formerly A.S.M.O., Durham) ; joined Society 1909.

Metropolitan Branch.—Dr. J. N. Dobbie (formerly Senior M.O., L.C.C.) ; joined Society 1923. Dr. N. M. Donnelly (formerly T.O., Deptford) ; joined Society 1920.

The name of Dr. A. Priestman, proposed by the Home Counties Branch, was withdrawn, as he was reported to have returned to active practice since his retirement.

The meeting next proceeded to the election of the following as Fellows of the Society, having been duly proposed and seconded : Barlow, Beryl A., M.B., CH.B. (MANCH.), D.P.H. ; Bramwell, John Byron, M.B., B.CH. (CANTAB.), D.P.H. ; Brown, Isobel Campbell, M.B., CH.B. (ABERD.), D.P.H. ; Cobbe, Aileen, M.B., B.S. (LOND.), D.R.C.O.G. ; Crosby, Joseph Henry St. Brendon, M.B., CH.B. (LIV.), D.P.H. ; Dobbin, Muriel J. W., M.B., CH.B. (GLASG.) ; Egan, Dorothy F., M.R.C.S., L.R.C.P., D.P.H. ; Elliott, Ronald W., M.D., M.SC. (SHEFF.), D.P.H. ; Gillet, Joseph Adrian, M.B., CH.B. (LIV.), D.P.H. ; Hay, Robert Kenneth, M.D. (BELF.), D.P.H. ; Hill, Rosetta, M.B. (BELF.), D.P.H. ; Hird, Margaret D., M.B., CH.B. (EDIN.), D.P.H. ; James, Dorothy Mary, M.D., B.CH. (WA), D.P.H. ; Kershaw, Geoffrey Ross, M.A., M.R.C.S., L.R.C.P., D.P.H. ; Lawson, Thomas Oliver Prescott, M.B., CH.B. (GLASG.) ; North, Harold Deacon Barker, M.SC., M.B., CH.B. (MANCH.), D.P.H. ; Power, John Gabriel Peter, Capt. R.A.M.C., M.B., B.CH., B.A.O., N.U.I. (CORK) ; Rees, Jennet, M.B., CH.B. (LIV.), D.P.H. ; Reynolds, Joseph, L.R.C.P. & S. (EDIN.) ; Solomon, Louis, B.A., M.B., B.CH., B.A.O. (DUB.), L.M. (ROT.), D.P.H., D.C.H. ; Stewart, Walter, Major R.A.M.C., M.B., CH.B. (ABERD.), D.P.H. ; Stuart, Gordon Hackworth, M.B., B.S. (LOND.) ; Stutt, John Charles, M.B., B.CH., B.A.O., D.P.H. ; Walker, Daniel Ironside, M.A., M.B., CH.B. (ABERD.), D.P.H. ; Wallace, Hugh Dawson, M.B., CH.B. (GLASG.), D.P.H., D.P.A. ; Wilson, James Stewart, M.B., CH.B. (ST. AND.), D.P.H. ; Wood, John Hay, M.B., CH.B. (ABERD.), D.P.H.

After nominations for the next election had been reported, the meeting proceeded to the joint discussion with the N.A.P.T. (see page 7).

COUNCIL MEETING

A meeting of the Council was held in the Hastings Hall, Tavistock House, W.C.1, on Friday, September 16th, at 10 a.m.

(23) The Chairman of Council, Sir Allen Daley, presided and there were also present the President (Prof. R. H. Parry) and Dr. W. Alcock, Mr. J. V. Bingay, Drs. C. Fraser Brockington, C. Metcalfe Brown, W. A. Bullough, H. D. Chalke, C. K. Cullen, James Fenton, Miriam Florentin, G. M. Frizelle, J. M. Gibson, F. Gray, F. Hall, W. S. Hebblethwaite, C. E. Herington, G. Hamilton Hogben, R. H. H. Jolly, John Maddison, Maurice Mitman, A. Morrison,

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CANDIDATES FOR ELECTION, OCTOBER 20th, 1949

The following, who have been duly nominated, will be balloted for :—

The abbreviations in first column indicate the Branches to which candidates wish to be attached, *viz.* :
Met. (Metropolitan) ; **Sc.** (Scottish) ; **Wa.** (Welsh) ; **E.A.** (East Anglian) ; **H.C.** (Home Counties) ; **Mid.** (Midland) ; **N.** (Northern) ; **N.I.** (Northern Ireland) ; **N.W.** (North-Western) ; **S.** (Southern) ; **W.E.** (West of England) ; **Y.** (Yorkshire) ; **E.M.** (East Midland). Overseas members are marked **N.S.W.** (New South Wales) or **C.O.** (Central Office).

FELLOWS :

Branch	*Name*	*Address*	*Appointment*	*Proposer and Seconder*
N.I.	**Abernethy, William Russel,** M.B., B.CH., B.A.O., D.P.H.	Ardnabrockey, Drumahoe, Londonderry	M.O.H., Londonderry C.B.	G. A. W. Neill E. E. Cromb
Y.	**Battersby, John,** M.B., CH.B. (GLASG.), D.P.H.	Maylands, Clarence Drive, Menston, Yorks	M.O.H., Shipley U.D. & Divl. M.O., West Riding	J. M. Anderson J. M. Gibson
Sc.	**Duncan, Eric Henry Weir,** M.B., CH.B. (ABERD.), D.P.H.	3, Shaw Place, Greenock	A.M.O.H., Greenock B.C.	Alexander Johnstone John Riddell.
N.W.	**Farquhar, Robert Warrender,** B.SC. (AGRIC.), M.B., CH.B. (ABERD.), D.P.H.	17, Parliament Street, Bury	Asst. Divl. M.O., Lancs C.C., M.O.H., Ramsbottom	T. Holme C. H. T. Wade
Sc.	**Hay, James R. W.,** M.D. (ABERD.), D.P.H.	11, Townsend Crescent, Kirkcaldy	M.O.H., Kirkcaldy B.C.	John Riddell E. Neil Reid
Met.	**Hay, Margaret Ann,** M.B., B.CH. (ABERD.), D.R.C.O.G., D.C.H.	20A, Overstrand Mansions, S.W.11	A.M.O. (Kensington), L.C.C.	Sheila Thomson Helen R. Buck
Sc.	**Insh, Alice Margaret,** M.B., CH.B. (GLASG.), D.P.H.	Ardenvohr, Bothwell, Lanarkshire	A.C.M.O.H., Lanark C.C.	G. M. Millar C. B. Wilson
N.W.	**Roberts, George Hugh Browse,** M.B., B.CH., B.A.O., D.P.H.	Tan-rallt, Cemaes Bay, Anglesey, N. Wales	A.C.M.O.H., Anglesey C.C.	G. J. Roberts O. J. Parry-Edwards
Met.	**Scott, Robert W.,** Lt.-Col., O.B.E., R.A.M.C., M.B., B.S. (DURH.), D.P.H.	R.A.M.C. Officers' Mess, Millbank, S.W.1	Asst. Dir. Army Health, War Office	A. E. Richmond A. N. B. Odbert
Mid.	**Thompson, Elizabeth,** M.B., CH.B. (EDIN.), D.P.H.	32, Dove Horse Lane, Solihull, Warwickshire	A.M.O., M. & C.W., Birmingham C.B.	Jean M. Mackintosh B. Hatherley
H.C.	**Whitman, Arthur Robert,** M.B., CH.B. (LIV.)	2, Severn Avenue, Gidea Park, Essex	A.C.M.O.H., Essex	Cecil Herington S. K. Donaldson

A. A. E. Newth, G. A. W. Neill, Wyndham Parker, Hugh Paul, R. C. M. Pearson, J. Riddell, E. Virginia Saunders-Jacobs, J. A. Stirling, J. A. Struthers, Mr. A. Gordon Taylor, Drs. A. L. Taylor, Nora Wattie, T. Ruddock West, Ann Mower White, H. C. Maurice Williams and J. Greenwood Wilson (38).

(24) *Apologies for Non-Attendance* were received from Drs. George Buchan, H. A. Bulman, W. G. Clark, F. M. Day, Sir George Elliston, Prof. W. M. Frazer, Sir Wilson Jameson, Profs. J. Johnstone Jervis, J. M. Mackintosh, R. M. F. Picken, Drs. J. E. Spence and G. McKim Thomas.

(25) *Minutes* of the meeting held on Friday, May 20th, 1949, published in PUBLIC HEALTH, June, 1949, pp. 193–195, were confirmed and signed.

(26) *Deaths.*—The Chairman reported with regret that since the last meeting of the Council the deaths of two prominent members of the Society had occurred, namely, Dr. James Ferguson and Dr. W. G. Willoughby (President 1910–11). The members stood in silence as a mark of respect and sympathy.

(27) *Matters Arising*:—

(*a*) *Social Workers in Mental Health.*—The report of a meeting of the Sub-Committee appointed to consider further evidence for the Mackintosh Committee was received. It was noted that a further meeting would be held shortly and the Chairman stated that the Sub-Committee would be glad to receive suggestions from members of the Society for consideration (see Appendix A).

(*b*) *Life Membership.*—It was reported that Drs. A. Priestman and H. W. Catto, whose names had been proposed for life membership, were now found to be ineligible.

(28) *Report of General Purposes Committee.*—Dr. J. M. Gibson (Chairman) presented the report of a meeting of the General Purposes Committee held on July 8th (Precis Appendix B with C and D).

The report was received and its recommendations adopted subject to the following amendments or additions.

Min. 69. *Annual Dinner.*—It was noted that the Minister of Health would be present at the Annual Dinner and would propose the toast of the Society.

Min. 72. *Salaries and Conditions of Service*:—

(*a*) *Avonmouth Docks.*—It was reported that this matter was now closed.

(*b*) *Medical Officers.*—It was reported that the local authority associations in England and Wales had now agreed to participate in a Whitley Medical Functional Council and that as soon as questions as to the claims of certain medical and non-medical bodies to be represented on the staff side had been settled a meeting would be held. It was resolved that the B.M.A. be asked to ensure that the Society was adequately represented on the Functional Council.

(*c*) *Dental Officers.*—The Executive Secretary reported that the Minister of Health wished to know if the Society desired to be represented at a preliminary meeting of the Dental Whitley Council. It was understood that the B.D.A. were undecided whether or not to send representatives to the meeting.

It was resolved that the Ministry of Health be informed that the Society would send representatives to the meeting and that the actual representation be left to the Dental Officers Group to determine in consultation with the Chairman of Council.

(*d*) *M.O.s and Medical Superintendents of Hospitals. Grading.*—Consideration was given to the question of the grading of medical officers who were medical superintendents of hospitals. It was resolved that the B.M.A. be informed that the Society was deeply concerned with the grave position which arose from the grading which was being offered to these officers and that it was felt that a strong protest be lodged with the Ministry of Health, attention being particularly drawn to the weakness of the appeals machinery. It was felt that there was a strong link between preventive health and the treatment of communicable disease and that medical officers of health should continue to act as superintendents of hospitals dealing with such cases.

In the meantime members concerned were to be advised not to sign contracts which contained reference to a grading lower than that of consultant but that they should offer to continue to do the work, consultants to be asked through the B.M.A. not to take posts falling vacant because an officer declined to accept the grading offered.

These resolutions were to be forwarded to the Secretary, B.M.A., for consideration by the Public Health Committee, the Central Consultants and Specialists Committee and the General Medical Services Committee.

Min. 75. *Labelling of Food Order.*—The Ministry of Food had stated that the prohibition of the sale of more concentrated solutions of acetic acid could not be justified to the trade and that they could not amend the requirements as to the warning to be printed on the labels of containers.

Min. 81. *British Medical Guild.*—It was resolved that the resolution contained in this paragraph be approved subject to the addition of the words "but this is not a condition of the support of the Society."

Min. 84. *National Health Service*:—

Information on Patients Admitted to Hospital.—The following letter dated July 8th was received from Dr. Godber, of the Ministry of Health:—

"We have recently discussed at one of our regular meetings of Senior Administration Medical Officers of Regional Hospital Boards, methods of improving the information given to medical officers of health about cases of infectious disease admitted to hospital. As a result of the discussion it was agreed that it should be possible for a hospital to send the medical officer of each local authority the following information:—

"(i) A card (under cover) from the hospital giving the patient's name, address, age and disease, and despatched as soon as possible after the patient's admission. This card would act as a check on cases where the general practitioner may have omitted to notify, and would be useful in all cases since the knowledge that a particular case has been admitted to hospital has a bearing on any action to be taken by the medical officer of health.

"(ii) A summary, probably at the end of each month, giving information about cases where the diagnosis in the original notification has been corrected. This could be put out in the form of a list giving the name, age, sex, address, tentative diagnosis on which the patient was admitted and the final diagnosis made in hospital. The list might also show separately the names of those who have developed a notifiable disease while in hospital.

"In addition to this, the medical officer of health would be notified in the usual way of the discharge of the patient, as these patients would clearly require follow up in many cases.

"Sir Wilson has asked me to put these suggestions to you in case the Society may wish to make any comments or further suggestions."

In reply, it had been requested that corrected diagnoses might be transmitted at once instead of at the end of each month. The Council agreed to refer this matter for the observations of the Fever Hospital Group.

Min. 86. *Standing Sub-Committee*:—

(*a*) *Hospital Administration.*—A letter dated August 3rd from the Chairman of the Central Health Services Council invited the Society to send representatives for an informal discussion with a Committee of the C.H.S.C. set up to deal with hospital administration. After consultation with Sir Allen Daley, who is a member of the Committee in question, Prof. R. H. Parry (President), Dr. Stuart Laidlaw, Dr. Fraser Brockington and the Executive Secretary attended at the Ministry on Tuesday, September 6th. Dr. Metcalfe Brown and Prof. W. M. Frazer had also been asked to attend if possible but were prevented by local engagements.

It was resolved that the members who had been asked to attend the meeting, together with Drs. F. Hall and Hugh Paul, be appointed a sub-committee (with powers to co-opt) to prepare written evidence on this matter and that the President (Prof. R. H. Parry) be appointed Chairman of the sub-committee.

(*b*) *Demand for, Training and Qualifications of Almoners.*—An enquiry had been received from the Ministry of Health as to whether or not the Society wished to submit evidence on the demand for, training and qualifications of almoners. It was resolved that a special sub-committee be set up consisting of the President, Sir Allen Daley, Drs. Fraser Brockington, J. M. Gibson, A. A. E. Newth, H. C. Maurice Williams and J. Greenwood Wilson to consider and discuss memoranda on the subject prepared by Sir Allen Daley and Dr. A. A. E. Newth and that recommendations arising from the discussion should be considered at the next meeting of the General Purposes Committee.

Min. 93. *Constitution of Regional Hospital Boards.*—The following letter, dated July 22nd, was received from the Chief Medical Officer of the Ministry of Health:—

"May I say right away that there was no intention to impose any sort of permanent embargo on the appointment of a regional hospital board of a serving medical officer of health? The Minister was anxious that the new boards should not have any undue proportion of local authority or other officers serving as members. Now that the boards have got down to work, I hope it may be possible to arrange for the appointment of medical officers of health from time to time as vacancies occur. I agree with you that there is need for securing a satisfactory relationship between regional hospital boards, local health authorities and local executive councils, and in this the medical officer of health has a very important part to play."

Min. 94. *Refuse Chutes for Multi-Storeyed Buildings.*—Dr. Struthers was unable to represent the Society in this matter and Dr. F. R. O'Shiel, of Stepney, had kindly agreed to act in his stead.

Min. 98. *Representation of the Society*:—

(*a*) *Central Council for Health Education.*—Dr. A. B. William-

son had now intimated his resignation. It was resolved that the vacancy caused by this resignation be not filled for the time being.

(*b*) *Royal Sanitary Association of Scotland.*—It was resolved that Dr. A. S. Hebblethwaite be appointed to represent the Society at the Annual Congress of the Royal Sanitary Association of Scotland in view of the fact that neither the President nor the President-Elect could attend on each of the four days of the Congress.

Min. 99. *Smallpox Cases.*—The A.M.C. had sent a further letter dated August 8th to the Ministry of Health as follows :—

" SMALLPOX NOTIFICATION

" Your letter of June 17th has been considered by my Public Health Committee who have asked me to inform you that they are by no means satisfied with the reasons you have advanced for the course of procedure adopted.

" They do not question the fact that county medical officers convey in full to district medical officers the notes received from the principal medical officers of the Ministry. They feel, however, that the delay necessarily involved, and which was in a few cases, considerable, in the transmission of these notes from the county medical officers should have been avoided. They point out that to have circularised the bulletins concerned to all medical officers of health throughout the country would have involved issuing approximately 600 compared with the 145 copies which were sent to medical officers of county boroughs and county councils only ; and they consider that the additional number ought not to be regarded as an excessive load upon the administrative machinery. Any delay at all in the transmission of information at a critical period of time in an outbreak of an epidemic disease, such as smallpox, might involve loss of life, and the committee feel very strongly that such chances should not be taken in order to ease the working of the Ministry's organisation.

" Moreover, they would emphasise that local sanitary authorities are autonomous bodies responsible by statute for dealing with epidemic disease ; and they feel that the method adopted for the circulation of information in connection with outbreaks of such disease should give full recognition to the statutory position.

" The argument advanced in your letter of June 17th, that by making this limited issue of information, which would otherwise have appeared in the first place in the medical press, the information was, in fact, disseminated rather earlier than would otherwise have been the case, would appear to be more of a condemnation of the normal practice than a defence of the emergency procedure actually adopted.

" One would have thought that, in a matter where speed was of the utmost importance, it was the moral duty of the Ministry to make sure that the fullest information was given with the least delay possible to all concerned, and that neither the excuse of organisational difficulty nor the claim that a partial improvement on normal procedure was achieved, was sufficient to justify the slightest unavoidable delay.

" My committee expressed the hope that very serious consideration may be given to the possibility of making more satisfactory arrangements in the event of any similar occasion arising in the future. " (Signed) G. H. BANWELL, *Secretary.*"

Min. 100. *Medical Administration.*—The minutes of the meeting of the Sub-Committee were received (Appendix D).

(29) *Subscriptions to the Society* (Min. 21)

A. The Hon. Treasurer reported that as requested at the last meeting of the Council a statement had been published in PUBLIC HEALTH (July, 1949) regarding the necessity of raising the subscription rates. No comments had been received from members. He reported further that there was little likelihood of a reciprocal arrangement being made with the B.M.A. owing to the precedent that would be created for other medical societies.

It was resolved that as from October 1st next rates of subscription to the Society be as follows :—

	£ s. d.
(i) *Fellows*	
(*a*) Whole-time medical officers in the government and municipal services	2 12 6
(*b*) Whole-time medical officers, within six years of the date of their first registration in the medical register	2 2 0
(*c*) Part-time and retired medical officers, overseas medical officers and medical practitioners (not officials) holding a degree or diploma in public health	1 11 6
(*d*) Where two members are husband and wife their joint subscriptions if both are in active practice should be four guineas or, if one is not in active practice, three and a half guineas.	
(ii) *Associates*	1 11 6

B. *Fully-Paid Life Members.*—It was resolved that the qualifying period for fully-paid life-membership be extended from 25 to 30 years and that the necessary amendment to the Articles be made.

(30) *Central Health Services Council.*—It was resolved that the following names be forwarded to the Minister of Health for consideration for a vacancy on the Central Health Services Council : Drs. C. Metcalfe Brown, J. M. Gibson, R. H. Parry and H. C. Maurice Williams.

(31) *Auxiliary Forces.*—The following letter, dated September 6th, from Dr. H. D. Chalke, was received :—

" Some months ago, all personnel of the Territorial Army were required to complete and return to the local offices of the Ministry of Labour and National Service, a form giving particulars of their civilian occupation and experience, and record of military service. These forms are now being returned to units and in certain cases they are endorsed ' may not be embodied.' Among the medical officers affected are included members of the civilian public health service.

" I am unable to discover who makes the decisions in these cases, but it is understood that neither the individual nor the local authority concerned are consulted.

" There is no need for me to stress the adverse effect which a policy of this sort is likely to have on the future of the medical services of the volunteer Territorial Army. Apart from this, however, the interference with the freedom of the individual doctor which such a procedure represents, causes very great concern. It would appear to call for investigation and explanation.

" I will be grateful if you will kindly bring this matter to the notice of the Council of the Society.

" You will, no doubt, have already seen the correspondence on this subject in the *B.M.J.* (Supplement—July 16th, August 20th and September 3rd, 1949), under the heading, ' Freedom of the Citizen '."

(Note by Executive Secretary. The cases referred to in the *B.M.J.* correspondence are of general practitioners and it appears that these are submitted to local executive councils and medical committees. Cases of public health medical officers are apparently adjucated elsewhere.)

It was stated that the practice described in the letter was under reconsideration and that the matter could be left in abeyance for the time being.

(32) *Resolutions from Branches and Groups* :—

(*a*) *Northern Branch* :—

" That the Northern Branch views with considerable apprehension the increasing amount of lay officer control in the Hospital Management Section of the National Health Service, and asks the Council to register a strong protest against the passing over of the medical superintendent's duties to lay officers."

It was resolved that this resolution be passed to the Hospital Administration Sub-Committee for consideration.

(*b*) *School Health Service Group* :—

" I have been instructed by the Council of the Group to send to you the following resolution passed at the last meeting on July 15th :—

' That this Group Council notes with regret that the Council of the Society saw fit to take no action, other than " noting " in regard to the circular letter sent by the Secretaries of the A.M.C., A.E.C., and C.C.A. to Directors of Education asking them to forbid school medical officers to respond to the letter from the Public Dental Officers Group of the B.D.A. seeking information about salaries of dental officers.

' The Group Council consider that a letter should be sent to the Secretaries of the three associations deploring the dispatch of such a letter to the Directors of Education, drawing their attention to Regulation 43 of the Handicapped Pupils and School Health Service Regulations 1945.'

(Signed) A. A. E. NEWTH."

It was resolved that the resolution be referred to the Genera Purposes Committee for consideration and report.

(33) *Representation of the Society.*—The following were elected.

(*a*) *B.M.A. Public Health Committee.*—Dr. F. Hall and Dr. Wyndham Parker.

(*b*) *Working Party on Midwives. Conference September 28th.*—Drs. Fraser Brockington, Hilda Davis, Miriam Florentin and J. D. Kershaw (or a deputy from the M. & C.W. Group). If Dr. Fraser Brockington is unable to attend the conference Dr. Kenneth Cowan was to be asked to attend in his stead.

(*c*) *Central Council for Physical Recreation.*—Dr. A. A. E. Newth.

(*d*) *Scientific Study of Juvenile Delinquency. Conference October 1st.*—Dr. R. C. M. Pearson.

(34) *Recommendations for Fully-Paid Life Membership.*—The The following recommendations for life membership from Branches were confirmed for presentation at the next ordinary meeting of the Society :—

(*a*) *Home Counties Branch.*—Dr. W. A. Bullough, formerly

C.M.O.H., Essex; joined the Society 1916.

(*b*) *Southern Branch.*—Dr. A. E. Druitt, formerly A.C.M.O.H., Hants; joined the Society 1923.

(*c*) *Welsh Branch.*—Dr. H. R. Tighe, formerly M.O.H., Swansea C.B.; joined the Society 1920.

(35) *Elections to the Council under Article* 19 (*d*), (*e*) *and* (*f*).—The Council elected the following:—

Article 19 (*d*).—Three Fellows of the Association: Drs. C. F. Brockington, J. Greenwood Wilson and R. H. H. Jolly.

Article 19 (*e*).—Two members nominated by B.M.A.—Drs. F. Gray and J. A. Ireland.

Article 19 (*f*).—Not more than four eminent persons interested in the advancement of public health: Dr. George Buchan, Sir George Elliston, Sir Wilson Jameson and Prof. J. M. Mackintosh.

(36) *Dates and Times of Meetings, 1949–50.*—The following list of dates and times of meetings of the Council and General Purposes Committee during the year 1949–50 was approved:—

1949

Thursday, October 20th, at 5.30 p.m. Ordinary meeting, Installation of President.

Friday, October 21st, at 10 a.m. General Purposes Committee.

Thursday, November 24th, at 5 p.m. Annual general meeting; 6.45 for 7.30 p.m. Annual dinner.

Friday, November 25th, at 10 a.m. Council.

1950

Friday, January 20th, at 10 a.m. General Purposes Committee.

Friday, February 17th, at 10 a.m. Council.

Friday, April 21st, at 10 a.m. General Purposes Committee.

Friday, May 19th, at 10 a.m. Council; 12.30 p.m. Ordinary meeting; Election of President 1950–51.

Friday, July 7th, at 10 a.m. General Purposes Committee.

Friday, September 15th, at 10 a.m. Council.

There being no other business the meeting closed at 12.45 p.m.

APPENDIX A

SUB-COMMITTEE ON MENTAL HEALTH SOCIAL WORKERS

A meeting of the Sub-Committee was held at Tavistock House, London, W.C.1, on Friday, July 8th, 1949, at 2.45 p.m.

Present.—Sir Allen Daley, Drs. C. Fraser Brockington, W. A. Bullough, J. M. Gibson and Prof. R. H. Parry.

Sir Allen Daley was elected to the chair.

It will be recalled that the Departmental Committee under the chairmanship of Prof. J. M. Mackintosh had now completed its interim report on questions relating to psychiatric social workers. The Ministry had now enquired whether the Society was prepared to put forward evidence on the long-term questions of the supply and demand, training and qualifications of all social workers in the mental health service.

Sir Allen Daley said that the subject seemed to divide itself into the following heads:—

(*a*) Mental Deficiency. Ascertainment, supervision and guardianship.

(*b*) Mental Disorder. (i) Prevention; (ii) Treatment of neuroses; (iii) action under Section 20 of the Nursing Act; (iv) reports to the medical staff of mental hospitals; (v) rehabilitation and aftercare, *e.g.*, reports on persons released on licence, and such activities as establishing social clubs for ex-mental patients.

(*c*) Child Guidance. Including residential schools for the maladjusted.

He thought that a question to which the Society should give attention was whether the health visitor could take a hand in the preventive side, possibly after taking a suitable refresher course. He mentioned that Hampshire County Council were now undertaking all extramural work and in certain respects acted as agents for the Regional Hospital Board. (A description of the Hampshire scheme appeared in PUBLIC HEALTH, July, pp. 210–212). Various points of view were expressed by other members of the Committee as to the qualifications necessary for the day-to-day preventive mental health worker who should take a part in ascertainment. There was a feeling in favour of probationary psychiatric workers who should "learn and earn" under the supervision of qualified P.S.Ws. These workers would be expected to take the examination of P.S.W. at the end of a fixed period or to stay on as unqualified assistants without promotion. The question was also raised of whether it was desirable to replace the present duly authorised officers and if so by whom. If it was suggested that the mental health work under all heads should be undertaken by an all-round worker consideration must be given to the sub-division of functions. It was agreed that members of the sub-committee should put ideas resulting from this discussion on paper and forward them as soon as convenient to the Executive Secretary. It was also agreed to request Dr. Hugh Paul (Smethwick) to give his views.

APPENDIX B

GENERAL PURPOSES COMMITTEE

(66) A meeting of the Committee was held in Committee Room "B," Tavistock House, W.C.1, on Friday, July 8th, at 10 a.m.

Present.—Dr. J. M. Gibson (Chairman), The President (Prof. R. H. Parry), Drs. C. Metcalfe Brown, G. F. Buchan, W. A. Bullough, W. G. Clark, C. K. Cullen, Sir Allen Daley, Drs. James Fenton, F. Hall, C. Herrington, Prof. J. Johnstone Jervis, Drs. R. H. H. Jolly, J. A. Stirling, H. C. Maurice Williams.

Apologies for Absence were received from Prof. W. M. Frazer, Drs. Miriam Florentin, M. Mitman, A. A. E. Newth, Hugh Paul and Mr. A. Gordon Taylor, L.D.S.

(67) *Minutes* of the last meeting held on April 22nd, 1949, and published in PUBLIC HEALTH, June (pp. 195–199) were confirmed and signed by the Chairman.

(68) *Annual Dinner* (arising from Minute 44).—The Chancellor of the Exchequer would be unable to attend the Annual Luncheon, proposed to be held on September 16th, and arrangements had therefore been begun for an Annual Dinner, for which accommodation was available on Thursday, November 24th, and it was agreed that the Annual Dinner be held on this date. It was understood that this date was convenient to the Minister of Health, who would be officially invited to attend by the President-Elect. It was agreed that the charge to members should be 22s. 6d. per head to cover service percentage and to make provision for official guests.

(69) *Information regarding Patients Discharged from Hospital* (Min. 41).—The Committee received the report of a conference of representatives of the Society and of the Central Ethical Committee of the B.M.A. on the disclosures of information regarding patients discharged from hospital (Appendix C). The report would be considered further after consideration by the Council of the B.M.A.

(70) *Standing Joint Committee of the Society of M.O.H. and of the Sanitary Inspectors' Association.*—The minutes of a meeting of this Committee held on June 9th to deal with a particular case of difficulty between a M.O.H. and sanitary inspector were considered. It was agreed that the report (as applicable to this case only) be received.

(71) *Training of Health Visitors* (Min. 4, Council, 20.5.49).—After considering the minutes of a meeting of the Sub-Committee appointed to consider the revised memorandum on the training of health visitors it was resolved that arrangements be made for a meeting of the Liaison Committee with the nursing associations to discuss the functions, recruitment and training of health visitors and that the nursing associations be asked if there were any other matters that they would like placed on the agenda for the meeting.

(72) *Salaries and Conditions of Service*:—

(*a*) *D.P.H. Students.*—The Executive Secretary reported that, following a recent communication from the B.M.A., he had sent a letter to professors and lecturers responsible for D.P.H. courses, advising them that there were available several possibilities for temporary appointments for students who successfully passed their examination.

(*b*) *Part-Time Anaesthetist.*—The B.M.A. had accepted for publication an advertisement for the appointment of a part-time anaesthetist to a City Health Service. The President felt that, in the present circumstances, advertisements for all medical posts for which local authorities were responsible should be refused. Under the present policy laid down by the B.M.A., advertisements of a similar nature could not be refused. The Committee noted the position but decided to take no further action.

(*c*) *Avonmouth Docks Medical Scheme.*—A letter dated July 5th was received from the B.M.A., reporting further developments in this matter. The Public Health Committee had resolved that it was "opposed in principle to whole-time public health medical officers being allowed to undertake general practice," and this principle had been confirmed by the B.M.A. Council. The present letter also drew attention to the following resolution passed by the Annual Representative Meeting of 1936:—

> "The Representative Body deprecates the increasing tendency for the employment by Municipal Authorities of part-time and salaried medical officers not engaged in private practice for the performance of clinical work within the sphere of private practice, as this must lead to overlapping and waste, and considers that in the public interest and on medical grounds, the services of local private practitioners should be utilised for all clinical work wherever their suitability and competence, and other local circumstances, permit."

Also the A.R.M. of 1929 had adopted the following in regard to the question of encroachment on private practice:—

> "IV. The private practitioner and the public health medical officer are not therefore working in entirely separate fields, but each should be interested in and should associate himself, so far as possible, with the work of the other.
>
> V. Nevertheless, the general direction of services established by or under the auspices of the local authority should be entirely

within the province of the public health medical officer; and equally no clinical work should be undertaken by public health medical officers which can, with due regard to administration, be as well done by private practitioners."

The B.M.A. now asked if the Society was in full agreement on these expressions of opinion. Prof. Parry stated, however, that the two port medical officers involved were not whole-time, but part-time officers of Bristol Corporation. Apart from giving part of their time to National Dock Labour Board duties, they were also part-time officers of the Western Regional Hospital Board for V.D. clinics in the docks.

The Committee resolved to reply to the B.M.A. that, whilst the Society agreed with the principle that whole-time public health M.O.s should not undertake general practice, this principle did not seem applicable to the Avonmouth matter. The Executive Secretary was also instructed to reply that the passages quoted above were, in the view of the Society, out of accord with the changes in medical practice resulting from the National Health Service Act. The terms "private practice" and "private practitioner," for instance, needed redefinition. The question of participation by public health medical officers in the Occupational Health Service needed discussion, as did that of National Health Service general practitioners in local authority preventive services. He was to request, therefore, that discussion of these issues and of the resolution passed at the 1949 A.R.M. regarding reference of cases by school M.O.s to consultants or to hospital (see Min. 72 (*d*)) should be initiated through the machinery of the agreement for co-operation between the B.M.A. and the Society.

(*c*) *School Health Service.*—The attention of the Committee was drawn to a motion carried at the recent Annual Representative Meeting of the B.M.A. at Harrogate to the effect that, in the event of a "school child" needing hospital treatment or examination by a consultant, the arrangements should be made (except in cases of emergency) through the general practitioner with whom the child was registered and should not be sent by the school medical officer to any particular hospital or consultant. The Executive Secretary was instructed to write to the B.M.A. referring to this resolution and to the action taken by the B.M.A. in connection with the matter referred to in the preceding sub-paragraph, and calling attention to the agreement for co-operation between the Society and Association. It was felt that before resolutions were passed, such as that reported, or before action was taken on public health matters, the questions involved should be referred to the Society, and that this principle should be discussed with the B.M.A.

(*d*) *Public Health a Specialism.*—With reference to the argument that public health should be recognised as a specialism, the Executive Secretary drew the attention of the Committee to the institution in the U.S.A. of the American Board of Preventive Medicine and Public Health, which will have the power to grade public health medical officers as specialists.

(*e*) *Medical Officers of Health as Medical Superintendents of Infectious Disease Hospitals.*—A letter was reported from Dr. N. E. Chadwick, in which he stated that until the coming into force of the National Health Service Act he held a part-time appointment as medical superintendent of an infectious disease hospital, and since the appointed day had carried on the appointment on an agency basis. He had now been graded as a senior hospital medical officer. The Executive Secretary had referred the letter to the B.M.A. and they had advised that an appeal should be lodged against the grading.

It was resolved that all members who were in the same, or a similar, position to Dr. Chadwick should be advised to hold out for consultant status and not to accept the grading of senior hospital medical officer.

(*f*) *Consultants' Salaries.*—It was reported that the Chairman of the Joint Committee of the Royal Colleges and the Consultants and Specialists Committee of the B.M.A. had sent a letter to the Ministry of Health, dated July 5th, expressing dissatisfaction with the terms offered by the Minister for hospital medical staff and requesting that Whitley machinery be set up to deal with salaries and conditions of service for this part of the profession.

(*g*) *Arbitration.*—Dr. Metcalfe Brown said that he had been considering the arbitration aspect of the salaries situation. As the local authority associations had shown no willingness to negotiate in the Whitley machinery, he thought the time had come for a move in a new direction. He therefore urged that the B.M.A. be asked to request the Minister of Labour and National Service to institute arbitration, through the National Arbitration Tribunal provided under Defence Regulation 1305 of 1940, where a trade dispute was reported to him. Public health medical officers, being under contract to local authorities, were "workers" in the eyes of the law.

The Committee agreed to pass this request for consideration by the B.M.A. Public Health Committee.

(73) *Council and Committee Clerk* (Min. 45).—It was reported that arrangements had now been made with the Scottish Amicable Assurance Society for an Endowment Policy to be taken out to provide Mr. Bragg with a pension of £250 per annum at the age of 65 or the payment of a lump sum of £1,965 and accrued profits in the event of his earlier death.

(74) *Mineral Oil in Food* (Min. 48).—A reply had now been received from the Ministry of Food to the Society's letter, stating that the labelling of mineral oil in the manner suggested was outside that Ministry's powers and the matter had been referred by them to the Ministry of Fuel and Power, who had intimated that they were not prepared to adopt the recommendation.

(75) *Labelling of Food Order and Statutory Standards for Tomato Ketchup and Curry Powder* (Council Min. 7).—The members of the Sub-Committee appointed by Council had now considered the draft amendments proposed to be made to consolidate the Labelling of Food Order 1946, together with the proposed Statutory Standards for Tomato Ketchup and Curry Powder, and submitted their comments, which it was resolved to forward to the Ministry of Food.

(76) *Milk (Special Designations) Regulations* (Min. 49).—The comments of the Society on the three sets of Regulations had been forwarded to the appropriate Ministries.

The Ministry of Food had now given notice that a conference to be attended by representatives of interested bodies would be held at the offices of the Ministry on Thursday, July 21st, at 3 p.m. It was resolved that the President (Prof. Parry), Drs. J. N. Gibson, F. Hall, Wyndham Parker, Sir Wm. Savage and Dr. W. B. Stott be invited to attend the conference.

(77) *Tuberculosis Group* (Min. 53).—The following letter was reported from the Tuberculosis Group:—

> "At its meeting to-day (May 20th, 1949) the Tuberculosis Group Committee discussed the future of the Group. The suggestion of the Council that we should take steps to set up a Tuberculosis Group within the B.M.A. was approved and steps have been taken to this end.
>
> The Committee appreciates the help it has received from the Council in resolving its problems in these difficult times, and hopes the Council will be glad to know that it is the intention of the Group to remain in being for as long as possible. Finally, the Committee wishes to assure the Council that its services are now as always at the disposal of Council for any advice or opinion on Tuberculosis matters."

(78) *Tuberculosis Specialists.*—The Executive Secretary reported that at a recent meeting of Tuberculosis Specialists of the South-East Metropolitan Regional Hospital Board resolutions were passed criticising the method and results of grading of tuberculosis specialists in that region.

(79) *Institute of Almoners* (Council Min. 10).—It was reported that an informal discussion had taken place between the Chairman of Council and Miss Read of the Institute of Almoners in connection with the request of the Institute for information regarding the status and standards of, and the fees charged by, nursing homes. Sir Allen had explained that the powers of registering authorities were strictly limited and did not cover charges. He had suggested that the Institute should itself press for the publication of a comprehensive list of nursing homes with information as to types of case taken, charges, number of beds and nursing staff.

Advantage had been taken of the meeting to suggest to the Institute that contacts between almoners and health visitors had become of vital importance in successful collaboration between the hospital services and local health authorities.

(80) *Refresher Courses for M.O.H.s.* (Council Min. 6).—The suggestion of the East Midland Branch that consideration be given to the reintroduction of refresher courses for M.O.H.s., was discussed. It was resolved that such courses be arranged by the various groups of the Society, administrative and clerical work to be carried out by the Central Office staff.

(81) *British Medical Guild* (Council Min. 5).—The question of the basis upon which members of the Public Health Service should contribute to the funds of the British Medical Guild and the method of collection of such subscriptions was again considered. Dr. F. Gray, B.M.A. representative on the Council, attended and enlarged upon the suggestion made by the B.M.A. After considerable discussion, it was resolved to support the principle of the British Medical Guild but consideration of the details of the support was deferred.

(82) *District Nursing Training Syllabus* (Min. 56).—A letter dated May 18th from the Queen's Institute of District Nursing was received, with observations on some of the comments of the Society on the proposed revised syllabus of training for district nurses. The observations were noted.

(83) *Export and Slaughter of Horses* (Council Min. 11).—In accordance with the instructions of Council, Dr. J. B. Samson, of Romford, had been asked to give observations on the export and slaughter of horses, which he had done. It was resolved that the Minister of Agriculture and Fisheries be informed that the Society did not wish to submit any evidence on this question.

(84) *National Health Service*:—

(*a*) *Decentralisation of Functions under Part III of the N.H.S. Act.*

—It was reported that a questionnaire had been sent to each county M.O.H. in England and Wales.

(*b*) *Transfer and Compensation Regulations.*—A letter was received from Dr. C. Leonard Williams, of Barking, with regard to the question of the transfer to the service of county councils of officers who were engaged wholly or mainly on functions which were transferred to local health authorities on the appointed day under the N.H.S. Act. Consideration of the letter was deferred pending an analysis of the replies received to the above questionnaire.

(*c*) *Chiropodists and Speech Therapists.*—Invitations were received from the Ministry of Health for the Society to give evidence before two Committees which have been set up to consider the supply, demand, training and qualifications of (*a*) chiropodists and (*b*) speech therapists in the National Health Service and to make recommendations.

It was resolved that the invitations be passed to the School Health Services Group for their consideration.

(*d*) *Attendance at Conferences.*—Attention was drawn to Circular 49/49 of the Minister of Health with regard to the general policy which should apply to the attendance of members and officers of local authorities at conferences.

(*e*) *Functions of M.O.H.s.*—The following resolution was passed at a joint meeting of the County and County Borough Groups at its meeting at Brighton on May 25th :—

> It was resolved to recommend to the Council of the Society (1) that the Scottish and North of Ireland and County and County Borough Groups should be asked to get out lists of duties which they considered should be allotted to the medical officer of health of a local health authority and his assistants, bearing in mind the extent to which future recruitment to the service is likely to be influenced not only by conditions of service and rates of pay, but also by opportunities for varied and interesting work. The Groups had in mind that the clinical work hitherto done by public health officers may eventually be taken over by trainee-specialists or general practitioners, (2) that the Ministry of Health be asked to decree that local health authority medical officers of health should have a statutory place on local executive councils and hospital management committees.

It was agreed that the resolution be forwarded to all Branches and to the County, County Borough and County District M.O.H. Groups for consideration and comment.

(*f*) *Admission to Hospital* (Council 20.5.49 Min. 14).—The M. & C.W. Group had considered the question of arrangements for admission to hospital of maternity cases and had made the following recommendations :—

1. The case selection on social grounds should be made by the health authority staff.
2. It should be a principle that the midwife, and not the health visitor, should decide on the suitability or not of home conditions.
3. "Tidy administration" must be subordinate to local circumstances.
4. The Society might collect more information on what is occurring in different areas.
5. No recommendation should be made to the Ministry of Health before further information is obtained.

It was resolved that these recommendations be forwarded to Branches for their comments.

(85) *Food and Drugs Act* 1938. *Model By-laws.*—The Executive Secretary reported that a second draft of the proposed Model By-laws under the Food and Drugs Act 1938 had been received from the Ministry of Food. Copies had been sent to Drs. Belam, Martine and White for their observations.

It was resolved that their complete observations be circulated to the members of the General Purposes Committee.

(86) *Standing Sub-Committee* (Council Minute 7).—It was resolved that Drs. F. M. Day, A. J. Shinnie, Charles White, W. A. Belam and W. R. Martine be appointed a Sub-committee to deal with matters referred to the Society by the Ministry of Food during the summer interval between the meetings of the Council. It was resolved further that any other matters referred to the Society be dealt with by the officers.

(87) *Tuberculosis Regulations.*—A letter of May 30th from the Ministry of Health stated that the Rural District Councils Association had urged the Minister to introduce legislation at a convenient time whereby it would be made obligatory on a person suffering from tuberculosis, or a dependant of that person, to notify the local authority of his district of any change of tenancy so that before the house was relet the necessary disinfection, etc., should be undertaken. The Minister was of opinion that medical officers of health were already in a position to take the necessary action without additional legislation. It was resolved that the Ministry of Health be informed that so far as can be seen the Society agrees with the Ministry's view and that the R.D.C.A. be asked for details of any cases referred to them.

(88) *Medical Women's Federation.*—It was reported that the Medical Women's Federation had published a pamphlet on the supply and disposal of sanitary towels in schools and that an acknowledgment had appeared of the help given by Dr. A. A. E. Newth and the committee of the School Health Group of the Society, by Dr. Nora Wattie, and by all the school medical officers who replied to their questionnaire.

(89) *Local Government Boundary Commission.*—The attention of the Committee was drawn to the recent statement in the House of Commons by the Minister of Health announcing the winding up of the Local Government Boundary Commission.

(90) *Foot Health Education Bureau.*—Copies of the booklet entitled "Foot Inspection in Childhood and Adolescence" prepared by the Foot Health Education Bureau in consultation with the School Health Service Group were distributed for the information of the members.

(91) *Report of the Royal Commission on Population.*—The Executive Secretary reported that he had been asked by the Editor of the *Municipal Journal* at short notice to send comments from the point of view of medical officers of health on the Report of the Royal Commission on Population.

(92) *Conference of German Hygiene Specialists.*—A letter from the Foreign Office conveyed the invitation of German Hygiene Specialists and Microbiologists to attend their conference.

It was resolved to point out that the programme for the conference had already been completed and that if it was the wish of the German authorities to be given information of public health progress in this country an approach should be made during the organising stage of a conference and a time given for British representatives to give papers.

(93) *Home Counties Branch.*—The following resolution was passed at the meeting of the Home Counties Branch at Brighton on May 24th :—

> That the Council of the Society be asked to take steps to secure that, in the case of hospital management committees, at least one place on each committee filled by a medical officer in the public health service whose duties lie within the area appropriate to the Committee; and that when Regional Hospital Boards are appointing members of Hospital Management Committees, nominations be invited from the medical officers of the public health service of the area concerned.

It was resolved that a communication be addressed to the Ministry of Health on this matter.

(94) *Refuse Chutes for Multi-storeyed Buildings* (Council Minute 13).—At a conference held at the British Standards Institution on May 24th it was agreed to proceed with the preparation of a British standard for refuse chutes for multi-storeyed buildings and an invitation was extended to the Society to appoint a representative to serve on the committee. It was resolved that Dr. J. A. Struthers be asked to serve.

(95) *Child Health Conference—Joint Meeting with the British Paediatric Association.*—It was reported that on the previous evening there had been a meeting between Prof. Moncrief and Dr. Lightwood, of the B.P.A., and Drs. Mower White (M. & C.W. Group), J. K. Kershaw (School Health Service Group) and Maurice Mitman (Fever Hospitals Group) and the Executive Secretary regarding arrangements for the joint meeting on November 25th and 26th. The Committee endorsed the provisional arrangements.

(96) *The Society and Medical Civil Servants.*—A letter dated June 28th was received from Dr. A. T. Elder, President of the Northern Ireland Branch. Dr. Elder enquired if it was the policy of the Society to include medical civil servants in its membership, and set out the reasons for his enquiry. It was resolved that Dr. Elder be informed that it was the policy of the Society being a non-medico-political body to include medical civil servants in its membership; that in this country medical officers employed by the Ministry of Health were members and their membership was found to be extremely valuable as giving informal contacts outside the official level; and that it was felt that the same policy should be pursued in the Northern Ireland Branch, all medico-political action being referred to the B.M.A.

(97) *Printing of* PUBLIC HEALTH *and Roll of Members.*—The Executive Secretary reported that he had been unsuccessfully endeavouring to speed up the production of the journal and Roll of Members. The latter had been with the printers for some months but final proofs had not been received. The Executive Secretary was instructed to ask the printers to revise the publishing schedule and to make every endeavour to keep to the revised schedule in future. Unless some considerable improvement was made the Society would have to consider cancelling the order for the Roll of Members and placing future orders for printing with another firm.

(98) *Representation of the Society* :—

(*a*) *National Safety Congress, October 4th–7th.*—Central Hall, Westminster—Dr. C. A. Boucher.

(*b*) *Royal Sanitary Association of Scotland.*—Dumfries, October 4th–7th—Prof. Parry or Dr. H. C. Maurice Williams.

(*c*) *Central Council for Health Education.* (i). National Conference, November 8th–9th, Central Hall, Westminster—Dr. H. C. Maurice Williams. (ii). Representatives for 1949–50: Drs. W. A. Bullough, Miriam Florentin, J. F. Galloway, R. P. Garrow, Hamilton Hogben, E. K. Macdonald, R. L. Midgley, A. A. E. Newth, J. F. Pilbeam, Esq., Drs. J. A. Scott, H. C. Maurice Williams, A. B. Williamson, E. C. H. Huddy and G. W. H. Townsend.

(99) *Smallpox Cases.*—Dr. W. G. Booth, of Ealing, forwarded copies of correspondence between the Ealing Borough Council and the A.M.C. and the A.M.C. and the Ministry of Health with regard to the transmission of information about cases of smallpox from the Ministry to medical officers of health of counties and county boroughs only—the C.M.O.H.s. being expected to pass this on to District M.O.H.s. It was resolved to write to the A.M.C. supporting the action that was being taken to induce the Ministry of Health to transmit any available information on any serious epidemic to all local authorities in order to avoid the delay caused in the offices of county councils by reason of their having to prepare and send out a further circular to disseminate the information to the authorities legally responsible for dealing with communicable disease.

(100) *Medical Administration.*—The President (Prof. R. H. Parry), who was the Chairman at a meeting of the Sub-Committee appointed to consider the Future Status of Medical Administration held on the afternoon of July 7th, submitted a verbal report of the meeting. After a general discussion it had been decided that the members should each prepare a paper on the subject and that a further meeting be held at a later date to make recommendations.

(101) *Morbidity Information.*—During the course of the meeting Dr. W. D. T. Brunyate, of the Ministry of National Insurance, attended and informed the meeting that the Ministry was prepared to make available to local authorities information which would show the rise or fall in the number of new applications received for sickness benefit at local offices of the Ministry. M.O.H.s. would be able to telephone local offices on a specified day of the week and obtain figures for the preceding week and there would be a time-lag of only two days. Similarly, county M.O.H.s. would be able to obtain figures from Regional Officers. The figures would not be analysed and the area concerned by local offices would not necessarily be co-terminous with local authority areas.

Dr. Brunyate was thanked for attending the meeting and the offer he had made on behalf of the Ministry was gratefully accepted.

The meeting was adjourned for lunch at 1.20 p.m., resumed at 2 p.m., and was finally closed at 2.50 p.m.

APPENDIX C

DISCLOSURE OF INFORMATION REGARDING PATIENTS DISCHARGED FROM HOSPITAL

At a meeting held on Thursday, May 19th, 1949, at B.M.A. House, there were present :—

For the Society : Sir Allen Daley (in the chair), Drs. C. Metcalfe Brown, James Fenton, J. M. Gibson, A. A. E. Newth and H. C. Maurice Williams.

For the Central Ethical Committee, B.M.A. : Drs. Robert Forbes and J. G. Thwaites.

The Chairman explained the system of exchanging information between the appropriate departments, when the L.C.C. was a hospital authority, which enabled a dossier on the health of the individua school child to be compiled.

Circular 179, dated August 4th, 1948, issued by the Ministry of Education, recommended local education authorities to consult hospital management committees and boards of governors with a view to securing, in all the necessary cases, information for the confidential use of school medical officers regarding pupils discharged from hospital. In these cases the names and addresses are required. The provision of " after care " in accordance with Section 28 of the National Health Service Act would not be practicable in the absence of information regarding discharged patients.

He mentioned an experimental card in use in West Ham which was completed in triplicate in respect of each discharged child. Copies were thus available for the hospital, general practitioner and school medical officer. In " after care " cases a copy would also be sent to the Health Department. In another category of case in which medical officers of health required a greater knowledge of morbidity data, the name of the patient and the precise address was not needed and therefore the question of disclosure did not arise. The cards were so arranged that the name and address was not transferred on to the carbon copy which was passed to the medical officer of health.

Dr. Fenton referred to the following motion by Derby considered by the Annual Representative Meeting in 1945 :—

> " That school medical reports shall be made available only to the patients' own doctors. Other medical officers requiring school medical reports should first obtain the written consent of the parent or guardian."

The motion was referred to the Council and received further subsequent consideration by the Public Health and Industrial Medicine Committees. It was ascertained that the motion referred to facilities available for industrial medical officers to obtain, on request, school medical reports when examining young persons on entry into industry. The Derby Division felt that the interests of these young persons might be prejudiced if industrial medical officers were in a position to refuse applications for employment on the grounds of information obtained from confidential medical reports. The Industrial Medicine Committee disagreed with the views of the Derby Division and expressed the view that school medical reports should be made available to industrial medical officers in order that the child, on entering industry, should not be employed in a field of work which would be unsuitable on medical grounds. This matter was referred to in the report of the Industrial Medicine Committee, which was received and approved by the Council on July 22nd, 1947.

Dr. Thwaites said that the general practitioner and school medical officer share responsibility for the health of the child and it would not appear unreasonable for hospital reports to be sent to both the school medical officer and the family doctor. In the past co-operation in this connection had not always been ideal.

Dr. Newth referred to the difficulties which might arise through frequent changes in the family doctor.

The rights of parents were mentioned by Dr. Forbes, who suggested that the onus be placed on the parent to object to the disclosure of information to other parties. It was clear that there should be no after-care or treatment in the absence of consent.

The Chairman suggested that persons entering hospital should be asked to sign an intimation that, in the absence of anything to the contrary, it would be assumed that they raise no objection to the disclosure of information to the appropriate medical officer of the local authority or to the family doctor.

The need for informing parents of their right to prevent such disclosure was stressed but Dr. Fenton was anxious to provide a workable scheme which would not give rise to trouble between almoners and health visitors.

Dr. Metcalfe Brown pointed out that the problem of disclosure of information related principally to in-patients but would also apply in the case of certain selected out-patients.

It was decided to refer this matter to the Central Ethical Committee before the Society of Medical Officers of Health made representations to the Ministry. The Central Ethical Committee might like to examine the question from the point of view of placing the onus on the parent and leaving the hospital to submit confidential reports in all cases where no objection was raised.

The necessity for being more circumspect in the future was stressed by Dr. Forbes who drew attention to the new class of patient now on the general practitioner's list, who might be more inclined to object to disclosure.

Dr. Gibson stated that the passing of information from one doctor to another was done in the interests of the child and the Chairman agreed that both doctors should know something of the illness from which the child has suffered.

Dr. Metcalfe Brown said that each hospital management committee would have to make its own decision and foresaw a breakdown if the system were made too complicated. For many years the ethical position had not been covered.

Dr. Thwaites thought the position would be safe-guarded if notice of the intention to disclose information, and of the patient's right to object to such disclosure, were included on the hospital admission card. The onus would then be placed on the parent to object and if no objection were raised consent to disclosure could be assumed.

The Chairman felt that the Central Ethical Committee might be able to give advice as to the most satisfactory method of covering the ethical aspects.

It was agreed that the same considerations apply to the pre-school child as in the case of the school child.

Turning to the question of adult patients Dr. Thwaites suggested that all requests for after-care should come through the patient's own doctor but the Chairman mentioned the possible delay of from three to four days before the discharge note would reach the doctor. Dr. Thwaites did not see that this need cause great difficulty as the hospital can undertake to get in touch with the nurse where necessary and in cases of urgency can telephone to the doctor.

It was generally felt that the family doctor should have the earliest possible information, and that the nurse should not attend without instructions from the doctor.

Dr. Metcalfe Brown said that the primary duty of the general practitioner is to look after his patients but in cases where the almoner considers " after-care " of any kind to be necessary he hoped it would be possible to give the health department, without delay, sufficient information to provide adequate after-care.

Dr. Thwaites pointed out that all procedures undertaken by the hospital to obtain after-care for a patient and any disclosure of information entailed in these procedures were perfectly ethical *provided that* they were undertaken with the knowledge and consent

of the patient. What would be unethical would be the routine disclosure of confidential information to the health department concerning a patient on discharge from hospital and without that patient's consent.

Dr. Fenton stated that when at home the patient is in the care of the general practitioner, who must receive full co-operation from the health department.

The Chairman concluded by referring again to the pilot scheme being conducted in West Ham where the results would be assessed after a trial period of three months.

APPENDIX D

SUB-COMMITTEE ON MEDICAL ADMINISTRATION

A meeting of the above sub-committee was held at Tavistock House, London, W.C.1, on Thursday, July 7th, at 3.30 p.m.

Present.—Drs. George F. Buchan, W. G. Clark, Sir Allen Daley, Dr. J. O. F. Davies (deputising for Dr. H. M. Macaulay), Dr. Maurice Mitman, Prof. R. H. Parry and Dr. W. G. Patterson.

Prof. Parry was elected to the chair.

The following letter from the Executive Secretary which had been addressed to Drs. Patterson and Macaulay was read as setting out the purpose of the Committee :—

> At the last meeting of the General Purposes Committee we had under discussion the future status of the medical superintendents of infectious disease hospitals whose Group is still part of the Society. The discussion turned to the Minister of Health's proposals regarding remuneration of hospital medical staff, with the corollary that medical superintendents are likely to be offered different levels of remuneration for the times which they give to clinical and administrative duties respectively (see proposals 3 (d)).
>
> The Committee felt that the whole field of medical administration is under attack and that the same considerations apply both to medical officers of health, administrative medical officers of Regional Hospital Boards and medical superintendents of hospitals. They therefore recommended to the Council of the Society that a special committee of members of the Society should be set up to consider and report on the whole field of medical administration with the following membership :—
>
> The President (Prof. R. H. Parry)
> Sir Allen Daley (Chairman of Council)
> Dr. G. F. Buchan
> Dr. W. G. Clark (or a deputy from Scotland)
> Dr. James Fenton
> Dr. H. M. C. Macaulay
> Dr. Maurice Mitman
> Dr. W. G. Patterson.
>
> We hope that both Dr. Macaulay and you may be able to attend but in any case that at least one of you will be present to represent the Regional Board's administrators.

There was a long and free discussion on present-day indications as to the position of the medical administrator. It was agreed that so far as medical administration of hospitals was concerned the cause was lost as both laymen were opposed to the medical superintendent, and consultants were, at least, lukewarm if not hostile. The lay hospital administrators were favoured by the clinical consultants as a feature transferred from the voluntary hospital system. It was agreed by the sub-committee, however, that there were very strong arguments in favour of the medical superintendent as he had existed under the municipal hospital organisation. Dr. Macaulay's view, expressed through Dr. Davies, was that the wheel would go full circle in two or three years and the advantages of medical superintendents be recognised again.

Regarding regional hospital boards it was pointed out that although medical administration had been recognised at the regional level a proposal to have a medical adviser at the hospital management group level had been turned down.

There was a general feeling in the Committee that whatever might be judged to be the best additional qualifications to show skill or training in medical administration the only type of medical administrator who was wanted was the man who would also be valued high as a doctor. Turning to the position of medical officers of health, Dr. W. G. Clark urged a reorientation in the D.P.H. curriculum. Sir Allen Daley thought that any attack on medical administration of the health department would be weakened by the fact that other professional and technical officers were the heads of other departments in local government, *e.g.*, engineers, surveyors, accountants and architects. Dr. Clark foresaw a move in Scotland to put public health under regional administration with lay heads of the region.

Members of the Committee undertook to put the views expressed into written form and Sir Allen Daley said he would prepare a memorandum after reflecting over the views of his colleagues.

SCOTTISH BRANCH

President: (1948-9) Dr. J. R. Adam (C.M.O.H., Roxburghshire) : (1949-50) Dr. E. Neil Reid (C.M.O.H., Stirlingshire).

Hon. Secretary: Dr. J. Riddell (C.M.O.H., Midlothian and Peebles).

A meeting of the Branch was held in the City Chambers, Edinburgh, on Saturday, June 18th, 1949. Twenty members were present.

After various minor matters had been disposed of, a discussion (to which all Scottish medical officers of health and representatives from the Department of Health had been invited) took place on the advisability or otherwise of making measles and whooping cough compulsorily notifiable. It was agreed that benefit would be obtained from making whooping cough notifiable, but not measles.

With minor amendments, reports on infectious disease exclusion periods for school children, Philip Committee on milk services, and export and slaughter of horses, were also approved.

The question of training in medical administration, report for the Catering Trade Working Party, and report on the educational provision for physically handicapped and mentally defective children, were continued for further consideration.

In the afternoon the *Annual General Meeting* was held, also in the City Chambers. After approval of the Hon. Secretary and Treasurer's report, the following appointments of office bearers and representatives were made.

President: Dr. E. Neil Reid.
Vice-Presidents: Drs. W. G. Clark and J. R. Adam.
Hon. Secretary and Treasurer: Dr. J. Riddell.
Hon. Asst. Secretary and Treasurer: Dr. B. R. Nisbet.
Members of Council:
Regional: Drs. Kelman, Reekie, Monro, Fyfe, Allan, and Laidlaw.
Teaching: Dr. W. A. Horne.
Members not Medical Officers of Health: Drs. Raeburn, Fulton, and Smith.
Others: Drs. Guy, Drainer, Leask, Cuthbert, Wattie and McMichael.
Medical Officers of Health Society—Central Council: Drs. W. G. Clark and J. Riddell.
General Nursing Council: Dr. W. G. Clark.
Central Midwives Board: Dr. N. Wattie.
Queen's Institute of District Nurses: Dr. J. Riddell.
Scottish Association for Mental Hygiene: Dr. Wm. Telfer.
Scottish Association for Mental Hygiene—Northern Counties Association: Dr. I. C. Monro.
Association of County Councils: Drs. G. M. Fyfe, E. Neil Reid and J. R. Adam.
Public Health Sub-Committee of British Medical Association (Scottish Committee): Drs. W. G. Clark, B. R. Nisbet, G. V. T. McMichael, S. I. Laidlaw, E. Neil Reid and J. A. Cuthbert.
Scottish Council for Health Education: Drs. W. G. Clark, B. R. Nisbet, E. Neil Reid, J. A. C. Guy, S. I. Laidlaw and G. M. Fyfe.
Scottish Council for the Unmarried Mother and Her Child: Dr. A. Fulton.
Consultants and Specialists Committee—Scotland: Dr. S. I. Laidlaw; Dep., Dr. J. Riddell.
Scottish Rivers Protection Council: Drs. J. R. Adam and E. Neil Reid.

DENTAL OFFICERS' GROUP

President: S. K. Donaldson, L.D.S. (Chief D.O., Essex).
Hon. Secretary: J. V. Bingay, M.B.E., L.D.S. (Area D.O., Middlesex).

Group Council Meeting

A meeting of the Group Council was held at Tavistock House on Saturday morning, July 9th, 1949. Mr. K. C. B. Webster was in the chair and was assisted by Messrs. K. Batten, J. V. Bingay, M. Cohn, Mrs. Clausen, Messrs. G. M. Davie, S. K. Donaldson, H. B. Fleming, J. Fletcher, P. G. Oliver, J. F. Pilbeam, J. Rhys-Herbert, J. G. Richardson, J. Young, W. Ritchie Young, and J. F. A. Smyth, Observer from the Public Dental Officers' Group, British Dental Association. An apology for absence was received from Mr. A. G. Taylor.

Minutes of the previous meeting were read and confirmed. Arising therefrom the Hon. Membership Secretary (Mr. Cohn) said the Group membership now stood at 224. He felt that this increase over 172, which was the figure in September, 1948, gave cause for some satisfaction, especially in view of the difficulties under which the service was labouring at the present time.

Correspondence.

(*a*) The Hon. Secretary had written a letter to Sir Sidney Johnson, Secretary of the County Councils Association, asking

whether in view of the Group's Annual General Meeting, which coincided with the first anniversary of the coming into force of the National Health Service Act, he could give any information as to whether any of the Local Authorities' Associations had agreed to enter a Dental Functional Council of the National Health Service Whitley Machinery or if not could any such acceptance be expected in the near future. Sir Sidney Johnson in his reply stated that so far he was unaware that any of the Local Authorities' Associations had agreed to enter such machinery and that although he was unable to anticipate any decision that might be taken, nevertheless the Associations were meeting to consider the whole problem on Tuesday, July 26th.

(*b*) A letter from Mr. G. Littlefield, expressing concern at the British Dental Association's recommendations in connection with health centre salaries which embodied a commencing salary of £750 as against £900 in the Public Dental Officers' Scale. A reply had been sent pointing out that the £750 was intended to apply to those newly out of hospital, whereas in the Public Dental Officers' Scale a period of three years' post-graduate service was anticipated before entry into the Public Dental Service. It should also be remembered that in order to give priority to the local health and local education authorities' services and to attract into them dental officers, a higher rate of remuneration was necessary; and that, whereas in health centres, which normally would contain more than one dental operating room, newly appointed officers would work under the supervision of a more senior person, such conditions were unusual in the public dental service.

Reports of Officers.

(*a*) *Hon. Treasurer.* Expenditure during the year had been unavoidably heavy, nevertheless the Group's finances remained in a reasonably healthy condition.

(*b*) *Hon. Secretary.* The year had been one of tragedy. The service was in grave danger of extinction. Some areas had no dental officers at all. Others were seriously understaffed. The Dental Attendants Repeat Course in early January had been a great success. Unfortunately at the present time the Eastman Clinic, London, was not available, and courses would of necessity be in abeyance for the time being. It was hoped that the Eastman Clinic would be available later in the year and that activities would be resumed.

The annual dinner at the Criterion Restaurant has been a successful function. Some 75 members and guests attended. Sir Hugh Lucas-Tooth, Bart., M.P., Chairman of the Conservative Party's Health Committee, was the principal guest. The Joint Salaries Committee's scale of salaries for public dental officers has been adopted by both parent bodies. Advertisements below this scale were being refused in the *British Dental Journal, Medical Officer* and PUBLIC HEALTH. In spite of difficulties membership had not only remained constant but showed a gratifying increase.

(*c*) *Hon. Editor of Transactions.*" The amount of dental material appearing in PUBLIC HEALTH had been rather less than in the preceding year, but it would be remembered that meetings had been fewer. All the material submitted directly by him and on behalf of sub-groups had received early publication. He again paid tribute to the assistance given him by the Editor of PUBLIC HEALTH.

(*d*) *Report of Chairman of Council.* Mr. Webster extended his thanks to members of the Council for their loyal support and for the help that had been given him on a number of occasions by Mr. G. L. C. Elliston, Sir Allen Daley and Dr. G. Buchan. He referred to the very close liaison which existed between the Society and the British Dental Association. He, and frequently others, had been invited with him to attend meetings of the British Dental Association Remuneration Committee, and he thought they had been able to make valuable contributions to the deliberations. He thanked Mr. J. E. H. Duckworth and his successor as Chairman, Mr. J. Gillard Bishop, for the courtesy they had extended to him. He had maintained contact with the dental officers of the Ministry of Health and with Mr. John Baird, M.P., who had done much by questions in Parliament to further the interests of the Public Dental Service. Mr. John Baird was indeed a very good friend to the Group.

(*e*) *Report of Group Representatives on the Council of the Society.* The May Council meeting was fully reported in the June number of PUBLIC HEALTH but members might wish to be reminded of the passage some 20 lines from the foot of the second column of page 195, relating to the Society's efforts to gain some reciprocal arrangement with the British Dental Association and British Medical Association whereby reduced rates of subscription might be paid by members of both bodies.

Dental Hygienists.—The Joint Salaries and General Purposes Committee, in view of the experiment in the use of dental hygienists at present being undertaken by some authorities at the instigation of the Ministry, had this subject under review. They were also studying the New Zealand Scheme of Dental Nurses.

Election of Chairman of Council.—Mr. K. C. B. Webster was re-elected Chairman of the Council for a further year.

Branch and Group Reports held over

The Editor again apologises for the delay in publication of other reports, owing to the pressure on space in this issue owing to the length of the Council and Committee proceedings.

Forthcoming Group Meetings

Dental Officers' Group.—At the Hastings Hall, B.M.A. House, on Saturday, October 22nd, at 2 p.m.—Discussion on Dental Ancillaries (including the New Zealand scheme) to be opened by J. F. Pilbeam, F.D.S., R.C.S. (Chief D.O., Middlesex).

Maternity and Child Welfare Group.—Saturday, November 8th (Hastings Hall, B.M.A. House).—Speech Defects: Dr. Mary Sheridan (M.O., Children's Dept., Home Office). Friday, December 2nd (London School of Hygiene).—Whooping Cough Immunisation: Dr. W. C. Cockburn (P.H. Laboratory Service).

School Health Service Group.—Friday, October 28th (Hastings Hall, B.M.A. House), at 5.30 p.m. Spastic Paralysis: C. D. Agassiz, M.C., M.D., F.R.C.P., D.P.H. (M.S. Queen Mary's Hospital, Carshalton). Illustrated by films. Members of the M. & C.W. are cordially invited to attend.

Services Hygiene Group.—Friday, October 21st (Hastings Hall, B.M.A. House), at 5.45 p.m. Presidential address by Dr. H. D. Chalke, O.B.E. (Lt.-Col., R.A.M.C., T.A.)

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